ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

DATE:_____

PATIENT INFORMATION:

NAME:_____
First Middle Last

ADDRESS: _____
Number Street

_____ _____
City State Zip

HOME PHONE _____ WORK PHONE _____ OTHER PHONE_____

EMPLOYER:_____ OCCUPATION : _____

WORK ADDRESS:_____
Number Street City State Zip

BIRTHDATE: ____/____/____ SEX: M F __Single __Married __Divorced __Other EMAIL _____

SOCIAL SECURITY NUMBER:_____ DRIVER'S LICENSE NUMBER:_____

SPOUSE/SIGNIFICANT OTHER/RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT: __SELF __SPOUSE__PARENT __OTHER

NAME:_____ BIRTHDATE:____/____/____ SEX: M F

ADDRESS:_____
Number Street City State Zip

HOME PHONE_____ WORK PHONE_____ OTHER PHONE_____

WORK ADDRESS: _____
Number Street City State Zip

SOCIAL SECURITY NUMBER:_____ DRIVER'S LICENSE NUMBER:_____

INSURANCE INFORMATION :

PRIMARY INSURANCE:_____ SUBSCRIBER'S NAME: _____

CERTIFICATE/POLICY NUMBER:_____ GROUP NUMBER: _____

SECONDARY INSURANCE:_____ SUBSCRIBER'S NAME: _____

CERTIFICATE/POLICY NUMBER:_____ GROUP NUMBER: _____

NAME OF FAMILY DOCTOR_____
First Name Last Name Phone # Address City Zip

IN CASE OF EMERGENCY, NOTIFY: _____

RELATIONSHIP:_____ HOME PHONE _____ WORK PHONE_____

NEAREST RELATIVE NOT LIVING WITH YOU: _____ PHONE_____

REFERRED BY:_____ MAY WE THANK THEM? ___ YES ___ NO

I authorize you to give me reasonable and proper medical care. I consent to disclose my medical information to be used for treatment, payment and healthcare operations. I understand that this information will be kept in confidence and will not be shared without my permission.

I also authorize _____, my insurance company to pay benefits directly to_____. I authorize Dr. Yi to initiate a complaint to the Insurance Commisioner for any reason on my behalf.

SIGNATURE: _____ DATE:_____

-PLEASE SEE REVERSE-

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 660
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7962
WWW.adrianyimd.com

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and understanding of our payment policy.

Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept a variety of payment methods such as, American Express, Discover, MasterCard, Visa, Cash and Checks (when pre-approved). We will be happy to help you process your insurance claim-form for your reimbursement.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are usually covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 70% or 80%) of the "Usual and Customary". This statement does not apply to companies, who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility for the date the services are rendered. We realize that temporary financial problems may arise, if so, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to assist you.

I have read and understand the above.

SIGNATURE _____ DATE _____

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

MEDICAL HISTORY QUESTIONNARIE

We welcome the opportunity to participate in your medical care. To ensure maximum safety and efficiency, we ask that you provide accurate answers to the questions asked relating to your general state of health. All the information will be held confidential as part of your medical records. **PLEASE ANSWER EVERY QUESTION. DO NOT LEAVE A QUESTION BLANK.**

NAME:_____ DATE:_____

Age_____ Sex: ☐Male ☐Female Height_____ Weight_____

1. Please list **ALL** medications (including Vitamins, over the counter medications, occasional prescriptions and any homeopathic or herbal medications) you are currently taking or have taken within the last month. Include the following: **Medication, Dosage, and Reason for Medication.**

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

2. Are you allergic to any medications, foods, medical tapes, latex, etc.? Yes ☐No If yes, please list, including reaction experienced;

_____

3. Do you have hay fever or seasonal allergies? Yes No If yes, please explain, include method of treatment.

_____

4. Please list all medical, dental and cosmetic surgeries or procedures since birth, which included local or general anesthesia.

	Surgery	Surgeon (if known)	Date (if known)
1.			
2.			
3.			
4.			

5. Have you ever had an anesthetic? Yes No
If, yes, have you ever had problems with anesthesia? Yes No Please explain_____

_____

6. Has anyone genetically related to you ever had any problems with anesthesia? Yes No Please explain_____

_____

7. Do you or have you smoked (Includes all nicotine use)? Yes No If yes, please describe type, amount and duration of nicotine habit_____

8. Do you drink alcoholic beverages? Yes No If yes,please explain_____

9. Have you ever or are you currently addicted or habituated to any form of medicine, drugs, or alcohol? Yes No
If yes, please explain _____

_____

FAMILY HISTORY Include all members of your genetic family, living or deceased. Please specify your relationship to the family member.

Cancer_____Type_____ Diabetes_____ Hay Fever_____

Tuberculosis_____ High Blood Pressure_____ Heart Disease_____

Stroke _____ Asthma _____

QUESTIONNAIRE CONTINUES ON NEXT PAGE

HEART AND LUNGS

YES NO Have you ever had an abnormal chest x-ray or EKG? If yes, please list when and findings_____

YES NO Have you ever been hospitalized with pneumonia? If yes, please explain_____

YES NO Do you have chronic cough or night sweats? If yes, please explain_____

YES NO Have you ever had a positive TB (Tuberculosis) test? If yes, please explain_____

YES NO Do you have or ever had asthma, even as a child? If yes, please explain when it was diagnosed, method of treatment, and last attack_____

YES NO Do you presently have or have you had within the last two weeks, a cough? If yes, please explain_____

YES NO Have you ever been diagnosed with a heart murmur, MVP (Mitral Valve Prolapse), irregular heart beat, or do you have an artificial heart valve? If yes, please explain_____

YES NO Have you ever had a heart attack or heart surgery? If yes, please explain_____

YES NO Have you ever sought medical attention for chest pain or shortness of breath? If yes, please explain treatment_____

YES NO Do you have or have you ever been diagnosed with high blood pressure? If yes, please explain_____

ABDOMINAL CAVITY/ORGANS

YES NO Have you ever had any type of kidney disease or been on dialysis? If yes, please explain_____

YES NO Have you ever been diagnosed with jaundice? If yes, please explain_____

YES NO Have you ever had hepatitis? If yes, please explain_____

YES NO Have you ever had any type of liver disease? If yes, please explain_____

YES NO Do you suffer from heartburn, or have you ever been diagnosed with stomach ulcers?_____

YES NO Have you ever been diagnosed with diabetes? If yes, please explain_____

HEAD AND NECK

YES NO Do you suffer from frequent headaches? If yes, please explain_____

YES NO Have you ever experienced a period of unconsciousness or had a fainting episode? If yes, please explain_____

YES NO Have you ever had a seizure? If yes, please explain_____

YES NO Have you ever had a stroke? If yes, please explain_____

YES NO Have you ever been diagnosed with Alzheimer or dementia? If, yes please explain_____

YES NO Have you ever been diagnosed with thyroid disease? If yes, please explain_____

GENERAL HISTORY

YES NO Have you ever been diagnosed with HIV or AIDS? **(Please remember that this will be held confidential as part of your medical history)** If yes, please explain_____

YES NO Have you ever been diagnosed with any type of cancer? If yes, please explain_____

YES NO Do you have any back problems? If yes, please explain_____

YES NO Do you have arthritis? If yes, please explain_____

YES NO Do you have any physical disabilities? If yes, please explain_____

YES NO Do you have any bleeding tendencies, blood clots or been diagnosed with hemophilia? If yes, please explain_____

YES NO Do you take any medications to thin the blood (i.e. Heparin, Coumadin) If yes, please list_____

YES NO Have you used any aspirin or Vitamin E products in the past two week? If yes, please list_____

YES NO Do you have dentures, caps, loose teeth, bridgework or braces? If yes, please list_____

YES NO Have you ever had any unexplained weight loss or weight gain? If yes, please explain_____

Is there anything else you feel you should tell us?_____

FEMALES ONLY

Are you or could you be pregnant? YES NO Method of birth control:_____

Date of last menstrual period:_____ # of all prior pregnancies_____ #of live births_____

ADRIAN YI, M.D., INC.

16311 VENTURA BLVD, SUITE 550
ENCINO, CA 91436
T: 818-986-7900
F: 818-986-7952
www.adrianyimd.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective as of February 2021

This Notice of Privacy Practices applies to the following organizations.

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD, SUITE 550
ENCINO, CA 91436

if you have any questions about this notice, please contact our Privacy Contact, Annette Olsen, RN, Clinical Director at 818-986-7900 or at cd@affinitysurgical.com

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME OF PATIENT (PRINT):_____

SIGNATURE OF PATIENT OR GUARDIAN:_____

DATE:_____

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

PATIENT NAME:_____ **DATE:**_____

Medical photography is essential for legal documentation of your pre-operative condition and for planning of cosmetic surgery as well as medical education. I consent to photography of appropriate portions of my face or body in preparation for surgery and for post-operative follow-up to be made of me or my child (or person for whom I am legal guardian of). The undersigned grants Dr. Adrian Yi the on-going and un-restricted right to use the undersigned's image for general information, education, scientific, medical and public relations purposes.

Authorization and/or consent as outlined above is hereby granted. I hold the physician, it's agents and employees harmless from any claim for injury or compensation resulting from activities authorized by this agreement.

Authorization and/or consent as outlined above is hereby granted.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

CONSENT BY PARENT OR GUARDIAN:

I am the parent or legal guardian of_____, minor. I am authorized to sign this consent on his/her behalf, and agree on my own behalf and his/her behalf to the terms of the foregoing consent.

Parent or Legal Guardian Signature:_____ Date:_____

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

PROTECTED HEALTH INFORMATION DISCLOSURE RECORD

PATIENT NAME:_____ **D.O.B.:**_____

Please list any person that you authorize to discuss any appointments for financial matters with us. If any person should call requesting to make an appointment for you or to discuss any financial matters regarding your account, we will not assist them unless their name and relationship is listed on this form. This policy is in order to protect your personal health information.

Person(s) authorized to discuss my appointments, account, etc.:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please tell us the authorized methods of communications you prefer.
Check all the apply:

☐ Residence telephone Number:_____
Is it ok to leave a message with a call back number? Yes or No
Is it ok to leave a detailed message with a person? Yes or No
Is it ok to leave a message on an answering machine? Yes or No

☐ Work telephone Number:_____
Is it ok to leave a message with a call back number? Yes or No
Is it ok to leave a detailed message with a person? Yes or No
Is it ok to leave a message on an answering machine? Yes or No

☐ Cell phone Number:_____
Is it ok to leave a message with a call back number? Yes or No

Please tell us how you would like us to send written correspondence:

☐ Home address Address:_____

☐ Work address Address:_____

☐ Other Address:_____

Patient signature:_____ Date:_____

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 560
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

COVID-19 RISK INFORMED CONSENT

I, _____ (patient name) understand that I am opting for elective treatments/procedures/surgeries at Adrian Yi, M.D. that are not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19 has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to be spread by person-to-person contact; and as a result, federal and state health agencies recommend social distancing. I recognize that Dr. Adrian Yi and the entire staff at Adrian Yi, M.D. Inc. and Affinity Surgery Center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand that there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with elective treatments/procedures/surgeries. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through elective treatments/procedures/surgeries, and I give my express permission for Dr. Adrian Yi, the entire staff at Adrian Yi, M.D. Inc. and Affinity Surgery Center to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I been infected with COVID-19, and even if I do not have any symptoms for the same, proceeding with elective treatments/procedures/surgeries can lead to a higher chance of complication and/or death.

I understand that possible exposure to COVID-19 before/during/after my elective treatments/procedures/surgeries may result in the following: A positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatments/procedures/surgeries, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may case additional risks, some or many of which may not be currently known at this time, in addition to the risks described herein, as well as those risks for the elective treatments/procedures/surgeries itself.

I have been given the option to defer my elective treatments/procedures/surgeries to a later date. However, I understand all of the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired elective treatments/procedures/surgeries.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO TREATMENTS/PROCEDURES/SURGERIES AT ADRIAN YI, M.D. INC. AND AFFINITY SURGERY CENTER.

_____

Patient or Person Authorized to Sign for Patient Date/Time

_____

Witness Date/Time

ADRIAN YI, M.D., INC.
16311 VENTURA BLVD., SUITE 550
ENCINO, CALIFORNIA 91436-2131
T: (818) 986-7900 F: (818) 986-7952
www.adrianyimd.com

COVID-19 SCREENING QUESTIONNAIRE

1. Have you returned from a visit outside the United States and travelled by public transportation (i.e. Airplane, Train, etc..) within the past ten days?

   _____

2. Have you been in contact with a person who has returned from travelling out of the country by public transportation within the past ten days?

   _____

3. Have you had any of the following in the past 10 days?

   a. Fever of 100F or greater. If yes, when did the fever start? _____
   b. Do you have a cough? If yes, when did the cough start? _____
   c. Do you have difficulty breathing? If yes, when did this start? _____
   d. Do you have any other symptoms? If yes, please describe _____

4. Describe countries and cities, along with the dates, you or contact person visited:

   _____

5. Describe contact you had with person with COVID-19:

   _____

6. Date you or contact person returned to the United States:

   _____

_____ _____

Patient Name (Print) Patient Signature