

# PATIENT INFORMATION SHEET

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\*E-Mail Address: \_\_\_\_\_

Pharmacy Name /Address: \_\_\_\_\_

Sex: M  F  Other  Specify: \_\_\_\_\_ Marital Status: Married  Single  Divorced  Widow

Home Phone # \_\_\_\_\_

Cell # \_\_\_\_\_

Work # \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse/Partner Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Contact # \_\_\_\_\_

Emergency Contact Name and Contact # \_\_\_\_\_ ( ) \_\_\_\_\_

Primary Physician Name and Phone # \_\_\_\_\_ ( ) \_\_\_\_\_

How did you find us? Search Engine  YELP  Friend  \_\_\_\_\_ Physician  \_\_\_\_\_

## INSURANCE INFORMATION

**\*\*\*While we are willing to work with our patients in regards to insurance billing, it is the patient's responsibility to know provider status, policy limits, deductibles, exclusions, copayment, and authorization information\*\*\***

Primary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_

## Assignment of Benefits

I hereby authorize payment directly to Brian M. Chesnie for medical and/or surgical benefits, if any, otherwise payable to me for his services as described on the attached claim. I also realize that this may no represent the full payment for services rendered and I will be responsible for the balance due including copayments, coinsurance, and deductibles.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Authorization for Release of Records

I hereby authorize Dr. Chesnie and his staff to release my medical records to my insurance company and/or my other treating physicians for the purpose of healthcare operations and/or for the purpose of processing my medical claims. This authorization shall remain in effect as long as charges are being submitted on my behalf for insurance claim processing or as dictated by the payor.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Brian Chesnie, M.D., Inc.

1501 Superior Ave # 300

Newport Beach, CA 92663

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR  
USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**Your health information is protected and our Notice of Privacy Practices is available on our website or in office.**

We must release information for healthcare operations (i.e.-insurances, labs, pharmacy, other physicians). In some instances, it may be necessary to release your protected information to an immediate family member (spouse/child). In some instances we may need to obtain health information for the purpose of medication or healthcare reconciliation through HIE (health information exchange)

I understand that my protected health information will be released and/or obtained via HIE (health information exchange) for the purpose of record reconciliation at the discretion of my physician and I also understand that I have a right to limit its use.

I understand that Dr. Chesnie and his staff will follow the directions indicated. I also understand that I have a right to revoke this authorization in writing, at any time, by sending such notification to Brian M. Chesnie, M.D. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Please Initial Each Box

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I hereby authorize my protected health information to be used and/or disclosed to immediate family members (spouse/children), my treating physicians, and/or my health insurance company as necessary to carry out normal treatment/healthcare operations.

I consent to reconciliation of my medications and/or medical history via HIE health information exchange system)

\*It is requested that all patients communicate with the office through their secure online portal for NON URGENT issues. I understand that by requesting my test results or my medical records via standard email instead of using the secure online portal available to me, my records will not be encrypted and therefore are not secure. I understand that any correspondence or questions sent through standard email such as Gmail or Yahoo are not secure and Dr. Chesnie may not respond. For any URGENT issue, I understand that I must call the office to reach Dr. Chesnie, go to the nearest urgent care or hospital, or call 911.

I understand that I have a right to inspect or copy the protected health information to be used or disclosed as permitted under federal law. I also have a right to refuse to sign this authorization.

I authorize  I do not authorize Brian Chesnie, MD or his staff to leave test results on my home or cell phone (if the message is generic and does not identify you as the patient, results will not be left).

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name