REGATTA HEALTH

Patient Demographic Information

PATIENT:_____
LAST FIRST MIDDLE

ADDRESS:_____CITY:_____STATE:_____

ZIP CODE:_____PHONE:(___)_____DOB:_____AGE:_____SEX:_____

SOCIAL SECURITY:_____-_____-_____ MARITAL STATUS:_____

ETHNICITY:

- O HISPANIC OR LATINO
- O NOT HISPANIC OR LATINO
- O DECLINE TO SPECIFY

RACE:

- O AMERICAN INDIAN OR ALASKAN NATIVE
- O ASIAN
- O BLACK OR AFRICAN AMERICAN
- O NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- O WHITE
- O OTHER RACE
- O DECLINE TO SPECIFY

E-MAIL ADDRESS:_____

EMPLOYER:_____PHONE:(___)_____

EMERGENCY CONTACT:_____PHONE:(___)_____

REFERRING PHYSICIAN:_____

PRIMARY PHYSICIAN:_____

ADDRESS:_____PHONE:(___)_____

PRIMARY INS:_____

PRIMARY SUBSCRIBER:_____SUBSCRIBER DOB:_____

DO YOU HAVE A PRESCRIPTION POLICY OR PART D MEDICARE? YES_____NO_____

(IF YES, PLEASE SUPPLY CARD) ID#_____GRP#_____BIN#_____

PLEASE ENTER YOUR PHARMACY INFORMATION ON THE LINE BELOW:

NAME:_____PHONE:(___)_____

ADDRESS:_____

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS ILLNESS/INJURY, AND I HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED WITH PAYMENT MAILED DIRECTLY TO HIM. I AM FINANCIALLY RESPONSIBLE FOR ALL EXPENSES NOT COVERED BY MY INSURANCE BENEFITS. A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

SIGNATURE OF
PATIENT/INSURED:_____DATE:_____

Health History Form, Regatta Health

Name:_____Date:_____
Date of Birth:_____Age:_____Referring Physician:_____
Reason for referral:_____

MEDICAL HISTORY

Start Date	Diagnosis

PROCEDURE HISTORY

(Please include surgeries, in office procedures, and imaging.)

Date	Type of Procedure

MEDICATION ALLERGIES

Medication	Allergy

MEDICATIONS

Start Date	Medication name and dose	Purpose

Health History Form, Regatta Health

REVIEW OF SYMPTOMS

Constitutional:
__Recent fevers/sweats
__Unexplained weight loss

Skin:
__Skin rash, location _____

Musculoskeletal:
__Muscle weakness
__Muscle tenderness
__Joint pain
__Back pain

Genitourinary:
__Trouble starting urination
__Leaking urine
__Bloody urine
__Nighttime urination
__Unusual vaginal bleeding

Gastrointestinal:
__Nausea or vomiting
__Diarrhea
__Bleeding from the rectum
__Abdominal pain

Neurological:
__Headaches
__Visual disturbances
__Numbness or tingling of the hands or feet

Chest:
__Cough
__Shortness of breath
__Chest pain

Nose/Throat:
__Sneezing
__Runny nose
__Sore throat

Cardiac:
__Trouble laying flat
__Sleep interrupted by shortness of breath

Hematologic:
__Bruise easily
__Nosebleeds
__Gum bleeding

Psychological:
__Depressed mood
__Anxiety/stress
__Difficulty sleeping

SOCIAL HISTORY

Occupation:_____
Tobacco use:_____ packs per day, for _____ years. Quit _____
Alcohol use: _____ drinks per week. Prior heavy alcohol use? _____
Physical activity? _____
Who lives at home with you? _____
Advanced directive/Power of Attorney made? _____
Marital Status: Single Partner/Married Divorced Widowed Number of children: _____
Women: Date of last menstrual period _____

FAMILY HISTORY

Family Member	Diagnosis	Age at diagnosis

REGATTA HEALTH

❖ MICHAEL BENJAMIN, MD❖

7325 Medical Center Drive
Suite 301
West Hills, CA 91307
Phone: 818-570-2134 Fax: 818-835-0485

Release of Medical Information

Patient Name:_____DOB:____/____/_____

TO:_____
(Provider or Facility)

ADDRESS:_____

I hereby authorize and request you to release any and all medical records in your possession, concerning my medical care at your office or facility, to **Regatta Health**, at **7325 Medical Center Drive #301 West Hill, CA 91307.**

_____ _____
Patient/Representative Signature Date

_____
Relationship

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West Hills, CA 91307
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Release of Medical Information to Family Members

Patient Name:_____DOB:____/____/_____

Under HIPAA requirements, we are not allowed to disclose any medical information to anyone other than the patient without the patient's consent. If you wish to have your medical information be released to a family member, please indicate to whom and sign below. Only those listed below will have access to your medical information.

I,_____, authorize Regatta Health to disclose my personal health information to the person(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

1) Name:_____Relation to Patient:_____

   Phone:(____) _____-_____

2) Name:_____Relation to Patient:_____

   Phone:(____) _____-_____

3) Name:_____Relation to Patient:_____

   Phone:(____) _____-_____

Note: You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent that Regatta Health has already acted based on your permission. If you would like to revoke your authorization, send a written request to the address shown above. **Your authorization or refusal to authorize disclosure of your personal health information will have no effect on your enrollment, and/or establishment as a patient.**

_____ _____

Patient/Representative Signature Date

_____

Relationship

REGATTA HEALTH

❖ MICHAEL BENJAMIN, MD❖

7325 Medical Center Drive
Suite 301
West Hills, CA 91307
Phone: 818-570-2134 Fax: 818-835-0485

HIPAA Rights to Privacy

Patient Name:_____DOB:____/____/_____

I, _____, acknowledge that I have received a copy of Regatta Health's, Notice of Privacy Practices. This Notice describes how Regatta Health may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Patient/Representative Signature Date

_____

Relationship

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully.
Dr. Michael Benjamin believes that your health information is personal. The office keeps records of the care and services that you receive. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.
This Notice describes the privacy practices of Michael Benjamin, M.D., Inc. This Notice applies to all of the health records that identify you and the care you receive at the offices of Michael Benjamin, M.D., Inc. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

Michael Benjamin, M.D., Inc. and Affiliated Facilities

All of our hospitals, employed physicians, doctor offices, entities, foundations, facilities, home care programs, other services, and affiliated facilities follow the terms of this Notice. These hospitals and locations are shown at the end of this Notice.
The doctors and other caregivers affiliated with Michael Benjamin, M.D., Inc. who are not employed by Michael Benjamin, M.D., Inc. exchange information about you as a patient with Michael Benjamin, M.D., Inc. employees. These healthcare practitioners may also give you other privacy notices that describe their office practices.
All of these hospitals, doctors, entities, foundations, facilities, and services may share your health information with each other for reasons of treatment, payment, and health care operations as discussed below.
How Michael Benjamin, M.D., Inc. May Use and Disclose Your Health Information:
When you become a patient of Michael Benjamin, M.D., Inc. , we will use your health information within our organization and disclose your health information outside Michael Benjamin, M.D., Inc. for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.
Treatment:
We use your health information to provide you with health care services. We may disclose your health information to doctors, nurses, technicians, medical or nursing students, or other persons at Michael Benjamin, M.D., Inc. who need that information to take care of you. For example, a doctor treating you for a medical illness may need to ask another doctor if you have diabetes because diabetes may slow the healing process. This may involve talking to doctors and others not employed by us. We also may disclose your health information to people who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members.
Payment:
We may use and disclose your health information so that the health care you receive may be billed and paid for by you, your insurance company, or another third party. For example, we may give information about treatment you had here to your health plan so it will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive so we can get prior payment approval or learn if your plan will pay for the treatment.

Health Care Operations:
We may use your health information and disclose it outside Michael Benjamin, M.D., Inc. for our health care operations. These uses and disclosures help us operate Michael Benjamin, M.D., Inc. to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We also may combine health information about many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other persons at Michael Benjamin, M.D., Inc. for learning and quality improvement purposes. We may remove information that identifies you so people outside Michael Benjamin, M.D., Inc. may study your health data without knowing who you are.

Contacting You:
We may use and disclose health information to reach you about appointments and other matters. We may contact you by mail, telephone or email. For example, we may leave voice messages at the telephone number you provide us with, and we may respond to your email address.

Health-Related Services:
We may use and disclose health information about you to send you mailings about health-related products and services available at Michael Benjamin, M.D., Inc. .

Philanthropic Support:
We may use general demographic information about you to contact you in an effort to raise funds to support Michael Benjamin, M.D., Inc. and its operations. We also will tell you how to cancel these communications.

Patient Information Directories:
Our affiliated hospitals include limited information about you in their patient directories, such as your name and possibly your location in the hospital and your general condition (for example: good, fair, serious, critical, or undetermined). We usually give this information to people who ask for you by name. We also may include your religious affiliation in the directories and give this limited information to clergy from the community. We do not release this information if you are being treated on a psychiatric or substance abuse unit. Releasing directory information about you enables your family and others (such as friends, community-based clergy, and delivery persons) to visit you in the hospital and generally know how you are doing. We will not release any of this information to these persons if you tell the hospital's admitting department not to.

Medical Research:
We may perform medical research here. Our clinical researchers may look at your health records as part of your current care, or to prepare or perform research. They may share your health information with other Michael Benjamin, M.D., Inc. researchers. All patient research conducted at Michael Benjamin, M.D., Inc. goes through a special process required by law that reviews protections for patients involved in research, including privacy. We will not use your health information or disclose it outside Michael Benjamin, M.D., Inc. for research reasons without either getting your prior written approval or determining that your privacy is protected.

Organ and Tissue Donation:
We may release health information about organ, tissue, and eye donors and transplant recipients to organizations that manage organ, tissue, and eye donation and transplantation.

Legal Matters:
We will disclose health information about you outside Michael Benjamin, M.D., Inc. when required to do so by federal, state, or local law, or by the court process. We may disclose health information about you for public health reasons, like reporting births, deaths, child abuse or neglect, reactions to medications or problems with medical products. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a

health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

Authorizations for Other Uses and Disclosures

As described above, we will use your health information and disclose it outside Michael Benjamin, M.D., Inc. for treatment, payment, health care operations, and when permitted or required by law. We will not use or disclose your health information for other reasons without your written authorization. For example, you may want us to release medical information to your employer or to your child's school. These kinds of uses and disclosures of your health information will be made only with your written authorization. You may revoke the authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

Your Rights Regarding Health Information

Right to Accounting:
You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom Michael Benjamin, M.D., Inc. has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the Michael Benjamin, M.D., Inc. facility that maintains the records about which you want the accounting. We will not list disclosures made earlier than 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the medical records department of Michael Benjamin, M.D., Inc. or the facility that maintains the records. We will respond to you within 60 days. We will give you the first listing within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

Right to Amend:
If you feel that health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend, identify the Michael Benjamin, M.D., Inc. facility that maintains those records, and give the reason for your request. You must address your request to the Privacy Official of Michael Benjamin, M.D., Inc. Michael Benjamin, M.D., Inc. will respond to you within 60 days. We may deny your request; if we do, we will tell you why and explain your options.

Right to Inspect and Obtain Copy:
You have the right to inspect and obtain a copy of your completed health records unless your doctor believes that disclosure of that information to you could harm you. You may not see or get a copy of the information gathered for a legal proceeding or certain research records while the research is ongoing. Your request to inspect or obtain a copy of the records must be submitted in writing, signed and dated, to the medical records department of the Michael Benjamin, M.D., Inc. facility that maintains the records. (Requests for billing records should be sent to the billing departments.) We may charge a fee for processing your request. If Michael Benjamin, M.D., Inc. denies your request to inspect or obtain a copy of the records, you may appeal the denial within Michael Benjamin, M.D., Inc. .

Right to Request Restrictions:
You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in your care or the

payment for your care, like a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated, and you must identify the Michael Benjamin, M.D., Inc. facility that maintains the information. The request should also describe the information you want restricted, say whether you want to limit the use or disclosure of the information or both, and tell us who should not receive the restricted information. You must submit your request in writing to the medical records department of the Michael Benjamin, M.D., Inc. facility that maintains the information you want restricted or to Michael Benjamin, M.D., Inc. . We will tell you if we agree with your request or not. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications:

You have the right to request that we communicate with you about your health in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing, signed, and dated. It must identify the Southern California Spine Institute hospital or facility making the confidential communications and specify how or where you wish to be contacted. You need not tell us the reason for your request, and we will not ask. You must send your written request to the medical records department of the Michael Benjamin, M.D., Inc. facility making the confidential communications or to Michael Benjamin, M.D., Inc. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice:

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a paper copy of this Notice at any of our facilities or by calling Michael Benjamin, M.D., Inc. privacy office at 818-570-2134.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Michael Benjamin, M.D., Inc. or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with Michael Benjamin, M.D., Inc. , you must submit your complaint in writing to Michael Benjamin, M.D., Inc., 7325 Medical Center Dr. Suite 201, West Hills, CA 91307 or call us at 818-570-2134 to speak to the manager. You will not be penalized for filing a complaint.

Changes to This Notice

Michael Benjamin, M.D., Inc. may change this Notice at any time. Any change in the Notice could apply to medical information we already have about you, as well as any information we receive in the future. The effective date of the Notice is on the first page in the top right corner.

If you have questions about this Notice, you may telephone 818-570-2134 and ask for the privacy official.