Luther Mangoba, M.D. Inc.

PATIENT INFORMATION

Last Name First Name	**Date Birth** Age Sex	Marital Status Single [ ] Divorced [ ] Married [ ] Widowed [ ]
Home address	Home Phone	Social Security #
Employer Name and Address	Business Phone	Occupation
Emergency Contact Name and Address	Contact Phone	Relation to patient

PRIMARY INSURANCE

Name of Person Responsible for Account	Birth Date Age Sex	Relation to Patient Self Spouse Parent
Address (If different from patient's)	Home Phone	Social Security #
Employer Name and Address	Business Phone	Occupation
Insurance Carrier Health Plan	Subcriber #	Group #
Insurance Address	Insurance Phone	Effective Date

SECONDARY INSURANCE

Subscriber Name	Birth Date Age Sex	Relation to Patient Self Spouse Parent
Secondary Insurance Carrier Health Plan	Subscriber #	Group #
Secondary insurance Address	Insurance Phone	Effective Date

Authorization for Treatment:

I (or the undersigned on behalf of the patient) voluntarily consent to allow **Luther Mangoba, M.D. Inc.** physicians and staff to provide evaluation and/or treatments on a continuing outpatient basis and as an inpatient when necessary, as deemed advisable and necessary by **Luther Mangoba, M.D. Inc.** physicians and staff. I am advised that such treatment may include but is not limited to: physical examination, laboratory procedures, diagnostic imaging studies, and other office procedures. Furthermore, should I execute any type of Advance Directive for health care, I will provide a copy to **Luther Mangoba, M.D. Inc.** I will notify **Luther Mangoba, M.D. Inc.** of any changes to the Advanced Directive and provide an updated copy whenever a new Advance Directive is executed. I understand that I will be informed about the course of my treatment and that I am free to terminate my treatment with **Luther Mangoba, M.D. Inc.** at any time.

_____ _____ _____

Patient, Parent or Guardian Signature Date Relationship to patient

Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to **Luther Mangoba, M.D. Inc.** for any services furnished me. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____ _____

Patient, Parent or Guardian Signature Date Relationship to patient

Luther Mangoba MD inc

MEDICAL HISTORY INFORMATION

Mr./Mrs./Ms._____Date:_____

Allergies: ___None

_____
_____
_____
_____

Prior Surgeries:___None

_____
_____
_____
_____

Medical Problems:___None

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medications:___None

_____
_____
_____
_____
_____
_____
_____
_____
_____

Habits:___None

Alcohol_____
Cigarettes_____
Others_____
_____
_____

Family History:___None

_____
_____
_____
_____
_____

Luther Mangoba MD inc.
PATIENT CONTACT PROTOCOL

1. Please print the telephone numbers and email address, if any where you want to receive calls or information about you're appointments, labs or other health care issues that would come directly from our office Luther Mangoba, M.D. Inc.

   Home Phone:_____

   Work Phone:_____

   Cell Phone:_____

   Pager:_____

   E-mail: _____

2. May confidential messages (appointments, test results, referrals etc) be left on your home answering machine, cell phone or e-mail?
   Home Phone: Yes____ No____
   Cell Phone: Yes____ No____
   E-mail: Yes____ No____

3. If you do not have an answering machine, voicemail or e-mail address, may we leave a confidentially stated message at your place of employment to return our call:
   Yes____ No____

4. Please list the family members or other persons, whom we may inform about your confidential information, condition, diagnosis etc:

   Name:_____ Relationship_____

   Name:_____ Relationship_____

   Name:_____ Relationship_____

5. Please print the address where you would like all billing statements and/or correspondence from our office to be sent:

   Street_____

   City_____ State_____ Zip_____

The authorization to leave confidential messages at the locations and with the individuals named above will be valid until a more recent form is placed in the chart:

Patient Name:_____ Date:_____

Patient/Guardian Signature:_____

Luther Mangoba MD Inc
6377 Riverside Avenue Suite B101
Riverside, CA 92506
(951) 686-0004 phone (951) 253-9096 fax

Health Maintenance & Medical History

Drug Allergies	Date Recorded	Chronic Medical Problems	Date Recorded
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	
8		8	
9		9	
10		10	

Surgeries	Date Recorded	Family History	Date Recorded	Preferred Language
1		1		
2		2		
3		3		Occupation
4		4		
5		5		

Health Maintenance Care (enter date performed)

Pap	Mammo	Breast exam	DRE	FOBT	BE/colonosc.	FLP	FBS	Visual acuity	Audiometry

Immunization (enter date given)

Hep B	Hep A	PPV	Td	MMR	Var	PPD		Flu		

Advanced Directives

The Physician or a staff member has provided me with information concerning Advanced directives.
I am 18 years old or older. I have the option of creating an Advanced Directive for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives. I understand that Advanced Directives may be any one of the following:
1) A Durable Power of Attorney **2)** A Living Will **3)** My wishes written on paper so that others may use the document in deciding my medical treatment in the event I am unable to do so.

Patient's Signature Date:

LUTHER MANGOBA, M.D. INC.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003.

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by Practice Name

Privacy Contact. If you have any questions about this policy or your rights contact our office.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Practice Name. This includes for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside Practice Name that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

Fundraising. As a not for profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation.

PATIENT RIGHTS

You have the following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record our office has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. Our office is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. You have the right to request a restriction in our use or disclosure of your medical information for treatment, payment or health care operations. We are not required to agree to your request. In order to request a restriction in our use or disclosure of your medical information, you must make your request in writing, and must describe in a clear and concise fashion: (1) the information you wish restricted; (2) whether you are requesting to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. Due to agency policy, we are not able to provide information by email.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. You must make your request to amend your record in writing. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to our office. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our office in writing. You also may complain to the Secretary of Health and Human Services if you believe Practice Name has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Practice Name reserves the right to change its Privacy Policy based on the needs of Practice Name and changes in state and federal law.

the center for medical weight loss

WEIGHT CONTROL EXPECTATIONS QUESTIONNAIRE

Patient Name:……..Date:……

Email Address:……

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in *any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can reasonably be expected to occur.*

How did you hear about us? (Please circle all that apply to you) Press Enterprise, Local Magazine, Radio, Google, mdbethin.com, liwli.com, Parent, Friend, Doctor, Street Sign, Other?.....

How much weight do you expect to lose?..... Each week?….....…Each month?.....

What will happen if you don't lose that much or that fast? How will you react? ...…….

…….....

.....

If your weight loss slows down markedly or even completely stops for a while, will you understand the difference between fat loss and water loss?.....

What size clothes do you expect to be able to wear when you reach your goal weight?

……....

What do you expect from us (your medical counselors)? Be specific: ……...…..

……

Will it change your life in any way (for better or worse) when you reach your goal weight?

..……..…

Do you expect to be doing anything you are not doing now? (describe in detail)

……

……

……

Do you expect to STOP doing something you ARE DOING NOW? (Describe in detail)

……

……

the center for medical weight loss

Will you be able to handle compliments about how you look when you are of normal size?.....

Will your new “normal weight self” pose a threat to your relationship with "significant others?" (how specifically?)……...

.....

.....

How will family and friends respond to the “new you”?.....

.....

Do you expect to get a better job?.....

Will you get more respect from other people?(Who specifically)…….....

……..……..

Will you feel comfortable with these altered responses from others?.....

Will you be expected to perform better at work (or at home)?.....

Will you have to be more sociable than you are now?.....

Will you have to assume any new responsibilities (please describe)?.....

…….....

.....

What will happen if some of your expectations don’t come true? What might you do?

.....

.....

What do you expect to have to do to maintain your new weight?.....

.....

Will you continue to watch your food intake?.....Exercise?.....

Continue with professional medical monitoring?.....For about how long?.....

Do you have any other expectations than those listed above?.....Specifically, what are they?

……..……..

……

……

Patient Name:……..Date:……