

**JEREMY E. KASLOW, MD, FACP, FACAAI**  
**FAX to 714-565-1035 with any diagnostic reports available**

**POTENTIAL PATIENT BACKGROUND**

Date Sent to Patient: \_\_\_\_\_

Patient's Name:	If minor, parents:
Date of Birth:	Your occupation:
Street Address:	
City, State, Zip:	

<input type="checkbox"/> Home Phone #:	<input type="checkbox"/> Cell Phone #:
<input type="checkbox"/> Work Phone #:	Fax #:
Email Address:	

*Please check off best daytime phone number and time of day to contact you.*

Best Day(s) for Appointment:	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday
Best Time of day for Appointment:	<input type="checkbox"/> Anytime	<input type="checkbox"/> Early am(8-10)	<input type="checkbox"/> Late am(10-12)		
	<input type="checkbox"/> Early afternoon (2-3:30pm)		<input type="checkbox"/> Late afternoon (4-5pm)		
Name of Insurance Carrier:					
Type of Insurance:	<input type="checkbox"/> PPO	<input type="checkbox"/> POS	<input type="checkbox"/> HMO	<input type="checkbox"/> Tier out of network	<input type="checkbox"/> None
Insurance Restrictions:					
What are your out of pocket limitations: <input type="checkbox"/> None <input type="checkbox"/> Can't afford anything beyond small co-pays					
<input type="checkbox"/> Can not afford any out of pocket expenses					

How did you hear about us (be specific please)?
What major medical issues concern you?
Summarize your specific health goals:
List type of treatments you have tried:
How committed are you to following a nutritional program?
List any special considerations (vegan, sensitivities, etc):
Have you reviewed our website, <a href="http://www.drkaslow.com">www.drkaslow.com</a> ?

\_\_\_\_\_ ← Initial here to acknowledge that Dr. Kaslow is not affiliated with any HMO or medical group, payment in full at time of service is expected for Cash, Medicare, Medi-Cal, HMO, Blue Cross and Blue Shield/United Health Care, Health Net, CCN, and PHCS patients, and that you will be billed for missed appointments and late cancellations. We are not in network for most major PPOs and you may want to check before committing to an appointment. Lab fees are not included in the office consult charges. Your initials indicate 1) your understanding the basic philosophy of this medical practice; 2) you are seeking consultative care only for health reasons; 3) any interaction with this office is considered a Private Non-Negotiable Contract with Jeremy E. Kaslow, MD Inc. All legal guardians of a minor must sign in order to initiate care.

PLEASE ALSO FAX or MAIL A COPY OF ANY RECENT/RELEVANT LABORATORY REPORTS. If you have a brief summary of your medical needs or history, include this as well.

----- For Office Response Only -----

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Get MRR (all / lab only) | <input type="checkbox"/> Schedule ST (full/50/MT32) or Patch Metal Test | <input type="checkbox"/> See PT 1 <sup>st</sup> /at 1 <sup>st</sup> visit |
| <input type="checkbox"/> Send NP packet           | <input type="checkbox"/> 1 <sup>st</sup> Available JEK                  | <input type="checkbox"/> TMA at 1 <sup>st</sup> visit                     |
| <input type="checkbox"/> DNS/NA                   | <input type="checkbox"/> Routine JEK                                    |   |

Thank you for your interest and confidence in choosing to enter a  
**Private Non-Negotiable Contract**  
with our medical practice for consultation.

### **INFORMATION FOR NEW PATIENTS**

Because your first visit is especially important, we'd like to make it as smooth and fulfilling as possible. To accomplish everything you would like the doctor to address, please:

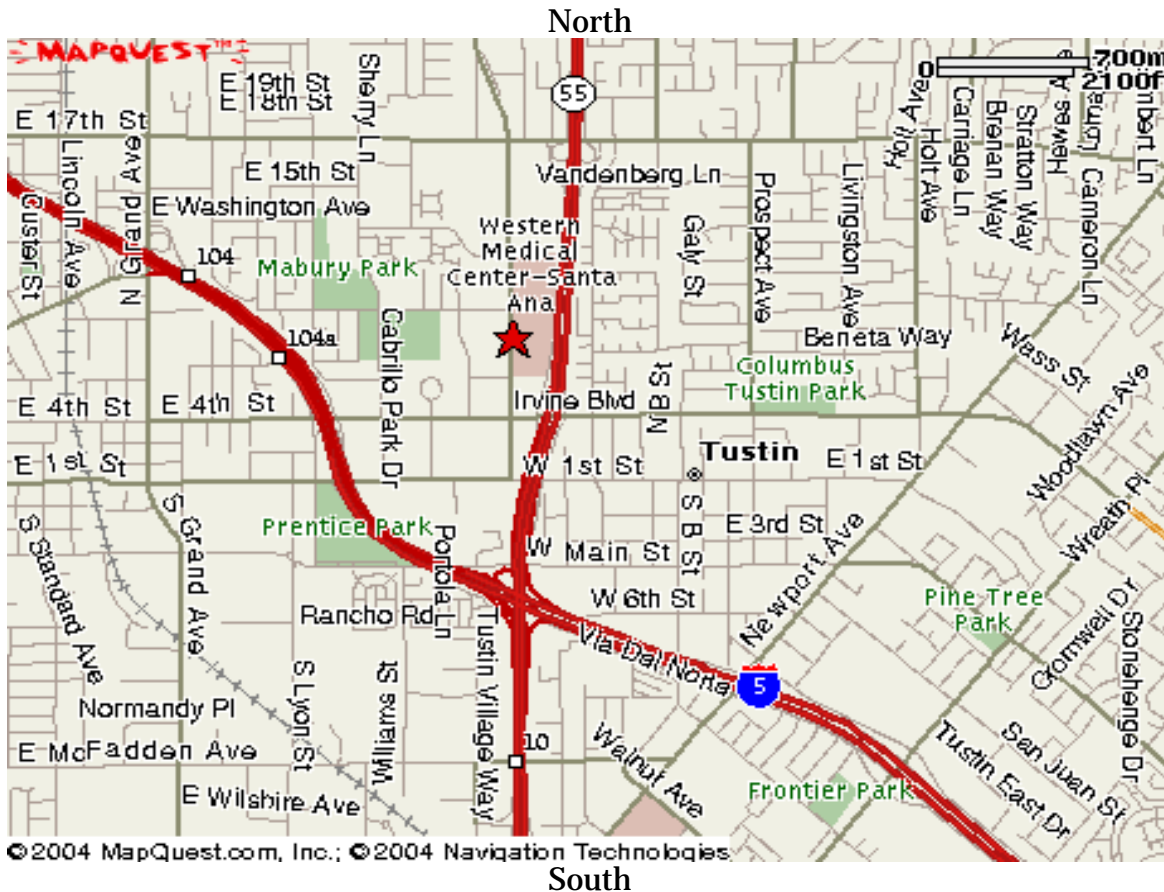
1. Complete all of the intake information and questionnaire before your appointment. Ideally we would like to have received the completed form at least one week before your first appointment. You may fax the forms to 714-565-1035. If your paperwork is not completed when you arrive at our office for your scheduled visit, your visit may be re-scheduled. Fill in all sections please!
2. Bring or have all of your doctors send us all **labs and medical records** within the past 5 years. The actual x-ray, CT, or other films are not necessary, just the reports. A request for medical records from your doctor(s) is attached. Send it or fax it to your doctor (s) and then call your doctor a week or two before your appointment to confirm the records have been sent to us.
3. Bring all **nutritional products and medications** you have used recently to your first appointment. Bring the actual product(s) in their bottles and a list.
4. Bring any other literature or information you would like the doctor or staff to review.
5. Plan to have a urine specimen and other diagnostic procedures done when you arrive. Avoid exercising, use of any unnecessary medications, nutritional supplements, and coffee on the day of the visit. If your appointment is before 10:00am, try to skip breakfast in case labs are needed in a fasting state.
6. Patients enrolled in Medicare will need to complete an additional form **before** being seen.
7. For patients who are minors, **BOTH** parents or guardians must sign the information form to prevent any conflict between parents with our management plan. Both parents are encouraged to attend the office consultations but this is not mandatory.

We have set aside a specific amount of time and staff for your consultation. Your acceptance of the appointment is an acknowledgement of your private non-negotiable contract with us for consultation. If you can not keep your appointment, we require 2 working days notice. You will be charged for failure to show without advance notice. Patients who repeatedly cancel and do not show for appointments will not be rescheduled.

As you will see, it is our intent to provide you with exceptional and personal care. We consider it an honor that you have chosen us, and we look forward to seeing you. You can find out more about our practice at [www.drkaslow.com](http://www.drkaslow.com)

Welcome to our medical office.

## DIRECTIONS TO OUR OFFICE



### “TIME MEDICAL PLAZA”

Our **two story brown wood** office building is located just west of the 55 Freeway and south of the 22 Freeway between 17<sup>th</sup> Street and 4<sup>th</sup> Street in Santa Ana.

- From the **North**, take the 5 Freeway southbound to the 4<sup>th</sup> Street offramp. Turn left onto 4<sup>th</sup> Street and go east to the stoplight at Tustin Avenue. Turn left onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.
- From the **South**, take the 5 Freeway northbound to the Riverside Freeway (North 55) offramp. Stay in the far right lane and exit onto the 4<sup>th</sup> Street offramp. Turn left onto 4<sup>th</sup> Street and travel west to the second stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.
- From the **Southbound 55 Freeway** driving towards Newport Beach, exit the 4<sup>th</sup> Street offramp. Turn right onto 4<sup>th</sup> Street and travel west to the stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.
- From the **Northbound 55 Freeway** driving from the Newport Beach area, exit the 4<sup>th</sup> Street offramp. Turn left onto 4<sup>th</sup> Street and travel west to the second stoplight at Tustin Avenue. Turn right onto Tustin Ave and travel north to 720 North Tustin, which is on the left side of the street before the first stoplight at Fruit Street.

Our office is on the first floor in Suite 104. Our office phone number is **714-565-1032**.  
We look forward to seeing you.

## OFFICE INFORMATION and POLICIES

**Welcome** to our office. In order to provide you with consistent quality care, we would like you to understand some of our office policies. The practice philosophy and other useful information can be reviewed on our website, [www.drkaslow.com](http://www.drkaslow.com). We encourage you to become informed about our practice.

When you agree to become a patient, you must agree to a PRIVATE NON-NEGOTIABLE CONTRACT between our office and yourself and assigns. This means that only you will decide on what is best for you independent of any outside influences such as insurance companies, etc. You are always in control of your care.

All **new patients** and existing patients that have not been seen for more than a year are seen as full consultations. Existing patients with an urgent medical problem will be seen as soon as possible but we focus on long term health consultations. Physical therapy and nutritional counseling is also available.

### APPOINTMENTS

New appointments are generally allotted 40 minutes with Dr. Kaslow. Although follow-up consultations are scheduled in 20 minute increments, if you need more than the time allotted, you may be charged for an extended visit. If you have time restraints, please let us know when you schedule your appointment or when you arrive. Please **call us** during the day of your appointment to see if we are running on time. We respect your valuable time. We do our best to give you the time you need as well.

The *early morning and early afternoon* appointments set the schedule for the remainder of the day. **Come 15-20" before** the scheduled time to allow vitals and other diagnostic studies to be completed before the appointment is scheduled to begin. For example, if your appointment is at 8:20 am, arrive at 8:00 am so that you have been prepared by 8:20 am for the consultation with Dr. Kaslow. Ask if you should be fasting or take medications before your appointment.

Please keep scheduled appointments or call at least **2 full workdays in advance** to let us know if you will be late or unable to come in. You will be charged for missed appointments. Individuals who repeatedly fail to show for appointments, cancel without advance notice, or are excessively late will be discharged from the practice.

### FEES

Your credit card information will be collected when you schedule your initial appointment, in accordance with our cancellation /no-show policy.

You are responsible for all of the **costs of services** provided you. Except Medicare, we furnish your *primary* insurance company with an electronic or paper claim as a courtesy to you. Special reports to insurance carriers will be charged according to the time spent, and you will be responsible for this expense.

Although we request payment for services from you at the time provided, we will submit a claim to your insurance so that you may be reimbursed directly. If we receive payment from your insurer, we will reimburse you for any overpayment. Some services may not be covered and will not be billed to your insurance.

### INSURANCE NETWORKS

For patients in Cigna or OCPPO/Foundation networks, we have an obligation to bill for you and accept a pre-determined reimbursement. It is considered insurance fraud to **accept insurance only** as payment in full if a co-payment is expected. Please don't put us in an awkward position by asking us to "accept insurance only." Let us know if you have extreme financial distress. Co-payments are due at the time service is provided.

Under all circumstances, **your account** is due in full within 45 days. If you need financing or need to make partial payments, please arrange this through Visa or MasterCard.

### LABORATORY TESTING

Valid and accurate lab results are important - the information helps determine your care. While there are many good **laboratories**, Dr. Kaslow may choose specific laboratories because they are either the best at what they do or are the only one that performs a specific type of analysis. They may be "out-of-network" or will not bill insurance. Routine labs are usually done through a lab in your preferred provider network. Check with your insurance carrier first if you have questions. Our staff will help advise you on approximate fees and coverage.

Dr. Kaslow personally reviews all **laboratory results** and may make preliminary comments and

recommendations that will be relayed to you by a staff member or via E-mail. There is a modest charge for this service. To review the patterns and implications of lab tests in more detail requires an office visit. You will receive a copy of your lab results; you should keep your own file of all reports and data.

### **PHONE CALLS and CONSULTS**

If you would like a **phone consultation** instead of an office visit, one can be arranged and billed according to the time spent on the phone. Some insurance companies reimburse this cost.

Certain medications such as antibiotics should not be prescribed without an in office examination. Your past use of a medication or wishes for **therapy over the phone** does not always mean it is appropriate or safe. Emergency appointments are available but must be limited to your urgent situation only.

### **NUTRITIONAL SUPPLEMENTS**

Dr. Kaslow has extensive experience, expertise, and success using **nutrition** and *specific* supplements. There is a huge difference among products and manufacturers. Public reputation, label contents, and cost mean nothing. Many supplements our patients find successful are not available in health food stores, pharmacies, etc. These are available to you through our Supplement Dispensary in this office (many need to be specially ordered) as a service to you. In addition to knowing the select manufacturers with impeccable standards of quality, we rely on feedback from our patients about specific products. In this way, your response helps others.

Although you are not obligated to obtain supplements from our office, we can not be responsible for what you purchase at your own risk elsewhere. We never accept opened products for credit or refund. If unopened, returns must be **approved in advance** within 30 days of purchase.

### **PHONE NUMBERS**

For all matters relating the office, Dr. Kaslow, billing, insurance, appointments, labs, etc. call 714-565-1032 or e-mail [billing@drkaslow.com](mailto:billing@drkaslow.com)

For all matters relating to nutritional supplements call 714-565-1036 or e-mail [supplements@drkaslow.com](mailto:supplements@drkaslow.com).

We encourage you to correspond with us via **E-mail** at [drkaslow@drkaslow.com](mailto:drkaslow@drkaslow.com). Be concise. Please don't

abuse the E-mail privilege. Multiple E-mails will be billed for the time needed to review and respond. Faxing questions and information is also a good way to contact us. Our fax number is 714-565-1035.

### **OUR RELATIONSHIP WITH YOU**

In some circumstances, you may want Dr. Kaslow to assume primary care responsibilities for you. This is not our policy but may be arranged on a case-by-case basis.

Relationships must be built on trust. When you sign the patient information form, you are entering into a Private Non-Negotiable Contract. If you have **problems** with any aspect of your care, let Dr. Kaslow know - we are on the same team as you. What we do is a labor of love; we consider it a privilege to share it with you.

We have been successful managing a variety of health conditions - feel free to ask us about a friend or family member you think might benefit from our services. Thanks for your confidence and referrals.

*Spring 2010*

**THIS PRIVATE NON-NEGOTIABLE CONTRACT MUST BE FULLY COMPLETED and RECEIVED BY OUR OFFICE BEFORE YOUR 1<sup>st</sup> CONSULTATION**

Feb 09

Patient's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Marital status \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Home phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birth date: \_\_\_\_\_  
 Fax # for correspondence: \_\_\_\_\_ Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer: \_\_\_\_\_ City : \_\_\_\_\_ Work ph: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_

Person responsible for payment: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 Address if not same as above \_\_\_\_\_ Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Employer: \_\_\_\_\_ City : \_\_\_\_\_ Work phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_  
 Other parent or  
 Emergency contact: \_\_\_\_\_ Day Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Relationship to patient: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  Friend  PPO book  My doctor  Internet  
 (please be specific)

**INSURANCE & BILLING INFORMATION:** Insurance Co \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
 Birth date of Insured \_\_\_\_\_  
 No Insurance  Medicare  Cigna  OC PPO/Foundation  
**We need a photocopy of your Policy Card and your Driver's License/Photo ID** ANNUAL DEDUCTIBLE \$ \_\_\_\_\_ Met this year? \_\_\_\_\_

**For ALL PATIENTS:** Regardless of your anticipated insurance coverage, you are responsible for the entire amount billed. For example, if your insurance policy has a deductible or a co-payment, this is to be paid at the time service is rendered. If your policy is no longer in effect, excludes conditions for which you are seeking care, does not cover a diagnostic or therapeutic procedure, you are ineligible for services provided to you, or does not pay us for any reason you will be liable for the full amount. It is your responsibility to find out the fees beforehand if you are not sure. Collection costs may be added. You will be charged for not showing up to your appointment(s) or canceling an appointment less than 1 full working day beforehand.

By agreeing to receive care and services in this office you are authorizing us to bill **your Credit Card** for any outstanding unpaid balance after 45 days.

**For PARENTS of MINORS:** Occasionally your child may need medical treatment when you are unavailable. To prevent delay, your agreement to have your child become my patient authorizes me to any x-ray, laboratory examination, medical diagnosis or treatment and hospital care deemed advisable by and rendered under the general or special supervision of Jeremy E. Kaslow, M.D. whether such a diagnosis or treatment is rendered at the hospital or office for your child when no legal guardian is present.

Because of the occasional disagreements about the care of a minor, **BOTH** parents or legal guardians must sign this form before Dr. Kaslow will evaluate or treat your child. Both parents must understand and agree in concept to the nature and approach of my practice. This authorization shall remain effective until your child is age 18 unless revoked in writing and received by Dr. Kaslow's office.

**For PATIENTS in EPO or PPO PROGRAMS:** If we are a contracted provider, we must submit your insurance claim directly. Failure to provide us with the necessary insurance information forces us to look to you for payment. **It is your responsibility to make sure we are a participating/contracted provider with your PPO/EPO/POS.** If your insurance has not responded to our claim within 45 days, you will be responsible for paying the balance due immediately. You will be notified that your credit card will be used to pay off your balance due. Excess payments received from the insurer after this time will be refunded as per your policy. Writing off your co-payment or deductible is not office policy and often violates the contract of the PPO agreement.

**For PATIENTS with KAISER, HMO insurance, MEDICARE, WORKER'S COMPENSATION, BLUE CROSS, BLUE SHIELD, UNITED HEALTHCARE, HEALTHNET, AETNA, GEHA, NATIONWIDE, MULTI-PLAN, PACIFICARE, GREAT WEST, CHOICE CARE, TRI-CARE or PHCS COVERAGE:** We are not contracted providers for these networks. You are responsible for full payment of all charges at the time of service. We may submit a claim on your behalf. Insurance discounts do not apply to out-of-network care. There may be extra fees for preparing reports and records your insurer requests. Some items are not billable to insurance and will not be submitted for reimbursement.

**Medicare patients** must sign an additional form before any care is provided. Ask if you did not receive it.

I hereby authorize Jeremy E. Kaslow, M.D. to render any procedure deemed necessary in diagnosing and treating my condition, or that of my dependent in an irrevocable hold-harmless agreement. I also authorize him to furnish information to my insurance carrier concerning the services provided and irrevocably assign to him all payments for the services rendered. I understand and accept full responsibility for all charges incurred whether covered by insurance or not. I will pay any legal costs I incur to or on this office, and all collection costs if my balance becomes delinquent (60 days after service). I acknowledge and authorize Jeremy E. Kaslow, MD Inc to charge my credit card for any remaining balance due on my account after 45 days.

The sole purpose of my consultation is for personal health care and I am not part of an investigation or inquiry about Dr. Kaslow' or any aspect of his practice. Signature below indicates irrevocable agreement to the above terms as a private non-negotiable contract.

I/We received and reviewed the office policy.  I/We reviewed the privacy policy of this office (HIPPA).

Signature of Responsible Person(s): \_\_\_\_\_ Date: \_\_\_\_\_  
 If patient under 18, both Mother AND Father must sign

**REQUEST FOR RELEASE OF RECORDS**

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

SSN: XXX-XX-\_\_\_\_-\_\_\_\_-\_\_\_\_ Medical Record Number: \_\_\_\_\_

From DOCTOR(s), CLINIC(s) or HOSPITAL(s):

Date faxed

- \_\_\_\_\_ fax: \_\_\_\_\_
- \_\_\_\_\_ fax: \_\_\_\_\_
- \_\_\_\_\_ fax: \_\_\_\_\_
- \_\_\_\_\_ fax: \_\_\_\_\_

Effectively immediately, I hereby authorize and request you to release by mail or facsimile to:

**Jeremy E. Kaslow, M.D., F.A.C.P., F.A.C.A.A.I.**  
**720 North Tustin Avenue Suite 104**  
**Santa Ana, CA 92705-3606**  
**714-565-1032 FAX 714-565-1035**

- All medical records concerning any aspect of my medical care.
- All medical records concerning any aspect of my medical care beginning \_\_\_\_\_.
- Only diagnostic data such as laboratory, biopsy, radiograph, imaging, spirometric, EKG, skin testing, or other test reports
  - the beginning of my illness or my first visit with you or your group.
  - \_\_\_\_\_.

The medical records requested are only to be used for medical care. They will not be released to another party without specific written authorization. A photocopy or facsimile of this request shall be as valid as the original and remain in effect for 12 months from the date of signature below. I may revoke this authorization in writing effective at any time. My next appointment with Dr. Kaslow is \_\_\_\_\_. Thank you for your cooperation and rapid response.

Signed: \_\_\_\_\_ /Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**PROHIBITION OF RE-DISCLOSURE and CONFIDENTIALITY NOTE**

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you making any further disclosure without the specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

The information released is intended only for the use of the individual(s) or entity(s) listed above and is confidential and legally privileged.