
**Hours**

8 a.m.- 5 p.m. Mon – Thurs, 8 a.m.- 4 p.m. Friday

Closed 12:30 p.m. - 2 p.m. for lunch, Closed for all major holidays

**Contact Information**

2216 Newport Blvd. Costa Mesa, CA 92627. **Phone: 949.631.9009 Fax: 949.631.1984**

Ample free parking located on the side/back of the building accessible from Virginia Place and Newport Blvd (one way street traveling north).

**After Hours**

Please call 949.631.9009 for physician on-call.

**After Office Hours**

For urgent medical issues after regular office hours that cannot wait until next business day, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours.

**Same Day/ Urgent Appointments**

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you the same or following day.

**Emergencies**

Call 9-1-1 for medical emergencies

**Medication Refills**

We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. If you prefer to call us, please call us during our regular office hours and allow 3-4 business days for us to refill your medications.

NEWPORT MEDICAL AND WELLNESS
MEDICAL • PHYSICAL THERAPY • MEDICAL SPA

## PATIENT INFORMATION

| LAST NAME | FIRST NAME | M.I. | NAME YOU PREFER TO BE CALLED | SEX |
|---|---|---|---|---|
| ADDRESS | APT # | CITY | STATE | ZIP |
| SOCIAL SECURITY # | BIRTHDATE | HOME TELEPHONE # | CELL PHONE # | |
| WORK TELEPHONE # | E-MAIL ADDRESS | | | |
| EMPLOYER | EMPLOYER ADDRESS | POSITION/ TITLE | | |
| HOW DID YOU HEAR ABOUT US? | | | | |
| EMERGENCY CONTACT NAME & TELEPHONE NUMBERS | | | | |
| WHO WAS YOUR PREVIOUS PRIMARY PHYSICIAN? | TELEPHONE # | | | |
| PHYSICIAN ADDRESS | | | | |

## GUARANTOR/ POLICY HOLDER INFORMATION

| LAST | FIRST NAME | M.I. | RELATIONSHIP TO PATIENT<br>SPOUSE PARENT OTHER: |
|---|---|---|---|
| ADDRESSS IF DIFFERENT FROM PATIENT | | | |
| BIRTH DATE | SOCIAL SECURITY # | | |
| GUARANTOR/ POLICY HOLDER'S EMPLOYER | EMPLOYERS ADDRESS | CITY | STATE ZIP |

## INSURANCE INFORMATION

| **1.PRIMARY INSURANCE PLAN** | GROUP NUMBER | POLICY NUMBER |
|---|---|---|
| TYPE OF PLAN OR COVERAGE<br>HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER | | |
| POLICY OWNERS NAME (GUARANTOR) | IPA | PRIMARY CARE PROVIDER |
| **2.SECONDARY INSURANCE PLAN** | GROUP NUMBER | POLICY NUMBER |
| TYPE OF PLAN OR COVERAGE<br>HMO PPO EPO MEDI-CAL MEDICARE MEDICARE SUPPLEMENT CASH OTHER | | |
| POLICY OWNERS NAME (GUARANTOR) | IPA | PRIMARY CARE PROVIDER |

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Newport Medical and Wellness Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Newport Medical and Wellness. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a $20.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE_____GUARANTORS SIGNATURE_____DATE_____

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**Patient Name:** _____ **Date of Birth:** _____

**Personal Medical History:** **Have you ever had (please circle all answers Yes or No)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | No | Yes | Anxiety | No | Yes | Pneumonia | No | Yes |
| Heart Disease | No | Yes | Depression | No | Yes | Meningitis | No | Yes |
| Heart Murmur | No | Yes | Epilepsy | No | Yes | Gonorrhea | No | Yes |
| High Cholesterol | No | Yes | Osteoporosis | No | Yes | Chlamydia | No | Yes |
| Diabetes | No | Yes | Thyroid Disease | No | Yes | Syphilis | No | Yes |
| Anemia | No | Yes | Asthma | No | Yes | Genital Herpes | No | Yes |
| Stomach pain or Reflux | No | Yes | Hives or Eczema | No | Yes | Genital Warts | No | Yes |
| Arthritis or Rheumatism | No | Yes | Migraines | No | Yes | Tuberculosis | No | Yes |
| Kidney disease | No | Yes | Gallbladder Disease | No | Yes | AIDS/HIV | No | Yes |
| Neuritis or Neuralgia | No | Yes | Colitis or other Bowel Disease | No | Yes | Race/Ethnicity: _____ | | |
| Bone or Joint disease | No | Yes | Jaundice or Liver Disease | No | Yes | | | |
| Sciatica, Back pain | No | Yes | Cancer * | No | Yes | * Type of Cancer:_____ | | |

If "yes" to any of the above, please describe further: _____

**If you have, or have had, any symptoms in the following areas to a <u>significant degree</u>, please briefly explain.**

| | | |
|---|---|---|
| Skin: | Back/Joints: | *Recent Changes in the following:* |
| Head/Neck: | Intestinal: | Weight: |
| Ears/Nose/Throat: | Bladder: | Energy level: |
| Lungs: | Menstruation: | Mood: |
| Chest/Heart: | Circulation: | Other pain or discomfort: |

**Other Medical Problems & Surgeries:**

_____

_____

**List All Current Medication and Dosages: (include non-prescription)**

_____

_____

**Allergies to medications or food:**

_____

**Describe the allergic reaction:**

_____

| | | | | |
|---|---|---|---|---|
| Do you drink alcohol? | No | Yes | Number of drinks _____ per week | Quit date: _____ |
| Do you or have you ever smoked? | No | Yes | How many cigarettes per day:_____ Quit date: _____ | How many years: _____ |
| Do you use drugs? | No | Yes | What kind:_____ | How many years: _____ |

Are you currently(circle one): Married Single Divorced Widowed

How many children do you have? _____ Ages: _____

Occupation:_____ Employer: _____ Highest level of education: _____

**Please list the last date you had any of the following:**

Pap Smear _____ Mammogram _____ Prostate Exam _____ Colonoscopy _____

**Family Medical History:** *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: _____

Mother: _____

Siblings: _____

_____

Paternal grandfather:_____

Paternal grandmother:_____

Maternal grandfather:_____

Maternal grandmother:_____

| **Medical Spa Services Questionnaire (please check all that apply)** | | |
|---|---|---|
| ☐ **Eyelash lengthening, fullness, thickness, or darkness** | ☐ **Facial Veins or Redness** | ☐ **BOTOX Cosmetics-finelines** |
| ☐ **Skin Care Products/Consult** | ☐ **Age Spots** | ☐ **Facial Folds** |
| ☐ **Blocky Skin** | ☐ **Chiropractic** | ☐ **Thin Lips** |
| ☐ **Weightloss (diet/medication)** | ☐ **Laser Skin Resurfacing** | ☐ **Facial Fullness** |
| ☐ **Acne Treatment** | ☐ **Personal Training-strength training** | ☐ **Cellulite Treatment** |
| | ☐ **Acupuncture** | ☐ **Microdermabrasion** |


**No Show Policy**

1) If there is need to reschedule or cancel your appointment, we ask that you notify us at least 24 hours in advance.

2) We have reserved this appointment time for you on the doctor's schedule in order to handle your medical needs in an efficient and timely manner. If notice of rescheduling or cancellation is within 24 hours of the appointment reserved for you, there will be a $50 charge.

3) Accumulation of 3 missed appointments may result in a notice of non-compliance and denial of rescheduling.

**Canceling Appointments**

1) As of January 2009, we will require 24 hours notice or 1 business day's notice, whichever is greater to cancel an appointment. Failure to provide this notice will result in a service charge of $50.00, which will NOT be covered by your insurance company.

2) We ask that one be respectful of our time and of other patients who are trying to get an appointment by adhering to this cancelation policy.

**Forms**

Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an

Evaluation and possible laboratory testing to complete. If forms are walked in without an appointment the charge will be $35.00, DMV physicals with required forms at time of the visit will be $125.00, and Sports/School physicals will require a waiver signed if no insurance coverage the charge will be $75.00


**Practice Insurance and Billing Policies**

1) All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

2) Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Newport Medical and Wellness Regulations pertaining to Medicare assignment of benefits apply.

3) The patient authorizes any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. They permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Newport Medical and Wellness. A patient understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.)

4) There is a $25.00 charge for all returned checks. All unpaid balances may be subject to 1.5% interest or minimum $6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

**5) NO SHOW POLICY-If there is need to reschedule or cancel your appointment, we ask that you notify us at least 24 hours in advance.**

**6) We have reserved this appointment time for you on the doctor's schedule in order to handle your medical needs in an efficient and timely manner. If notice of rescheduling or cancellation is within 24 hours of the appointment reserved for you, there will be a $50 charge. Accumulation of 3 missed appointments may result in a notice of non-compliance and denial of rescheduling.**

**7) APPOINTMENT CANCELATION As of January 2009, we will require 24 hours notice or 1 business day's notice, whichever is greater to cancel an appointment. Failure to provide this notice will result in a service charge of $50.00, which will NOT be covered by your insurance company.**


**Patient Responsibilities**

As a partner in your healthcare, you have the following responsibilities:

1) I will provide accurate health information to your doctor and update us with any health changes.

2) I will schedule routine physical exams and other health maintenance exams recommended to me by my doctor (Pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see my doctor for immediate problems. I will make appointments with my doctor to discuss routine health screenings.

3) I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that not following my treatment plans may put my health at risk

4) I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments my physician may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.

5) I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.

6) I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.

7) I will treat all providers and office staff respectfully and courteously.

8) I will fulfill my financial obligations for care provided to me in a timely manner.

9) I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.

10) I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.

11) If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care. Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

***I have read, understand, and agree to the above listed* PRACTICE POLICIES 2 page form**

| | |
|---|---|
| **PRINT NAME** | |
| **DATE** | |
| **SIGNATURE** | |


**Patient Consent for Use and Disclosure of Protected Health Information**

1) I hereby give my consent for John LaLonde, D.O. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by John LaLonde, D.O. describes such uses and disclosures more completely.)

2) I have the right to review the Notice of Privacy Practices prior to signing this consent. John LaLonde, D.O. reserves the right to revise its Notice of Privacy Practices at any time.

3) A revised Notice of Privacy Practices may be obtained by forwarding a written request to John LaLonde, D.O. 2216 Newport Blvd. Costa Mesa, CA 92627.

4) With this consent John LaLonde may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

5) With this consent, John LaLonde, D.O. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

6) With this consent, John LaLonde, D.O. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

7) I have the right to request that John LaLonde, D.O. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

8) By signing this form, I am consenting to allow John LaLonde, D.O. to use and disclose my PHI to carry out TPO.

9) I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, John LaLonde, D.O. may decline to provide treatment to me.

***I have read, understand, and agree to the above listed practice information***

| | |
|---|---|
| **PRINT NAME** | |
| **DATE** | |
| **SIGNATURE** | |