

Today's Date \_\_\_\_\_

**Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
last name first name m.i.

Address \_\_\_\_\_  
street apt # city state zip

Mailing Address \_\_\_\_\_  
If different than above city state zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Sex: M F Status: S M D W

**Additional Information for PATIENT or Guardian (Required)**

Name of responsible person if other than patient or if patient is a minor \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License #/State \_\_\_\_\_

Place of Birth \_\_\_\_\_ Occupation \_\_\_\_\_

**Emergency Contact Information**

Name of Person to Contact \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Check here to authorize CEI / CSI / CFI / LTHF to disclose your private health information to this individual

**Insurance Information**

**Primary Insurance (Courtesy only for LTHF)**

**Secondary Insurance (Courtesy only, all Clinics)**

Insurance Co. Name \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_

Subscriber I.D. # \_\_\_\_\_

Group or Policy # \_\_\_\_\_

Group or Policy # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**How Did You Hear About Us?**

Reason for Consultation \_\_\_\_\_

Referred By \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Or  Yellow Pages  Relative  Friend  Employee  Event  Other \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Other**

I would like to receive information about Let Them Hear Foundation and other CEI related activities e-mail address \_\_\_\_\_  Yes  No

CEI / CSI / CFI / LTHF may leave voice mail messages containing my private health Information on any of the phone numbers listed on this form  Yes  No

Language I would prefer reminder phone calls in \_\_\_\_\_



CALIFORNIA FACE & LASER INSTITUTE  
Matthew Mingrone, M.D.

**PATIENT INFORMATION FORM**

**APPOINTMENT DATE:** \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**Please check next to the procedures or treatments that you are interested in-**

- |   |  |
|---|--|
| <input type="checkbox"/> BOTOX Cosmetic                   | <input type="checkbox"/> Injectable Fillers (Juvederm/Restylane) |
| <input type="checkbox"/> Eyelid surgery                   | <input type="checkbox"/> Laser hair removal                      |
| <input type="checkbox"/> Facelift/Necklift/Minilift       | <input type="checkbox"/> Spider veins / leg vein treatment       |
| <input type="checkbox"/> Endoscopic browlift              | <input type="checkbox"/> Photo facial                            |
| <input type="checkbox"/> Cheek lift                       | <input type="checkbox"/> Broken capillaries on the face          |
| <input type="checkbox"/> Skin care                        | <input type="checkbox"/> Skin resurfacing/Active FX              |
| <input type="checkbox"/> Scar revision                    | <input type="checkbox"/> Acne scar treatment                     |
| <input type="checkbox"/> Facial liposuction               | <input type="checkbox"/> Chemical peel                           |
| <input type="checkbox"/> MicroLaserPeel/Microdermabrasion | <input type="checkbox"/> Ear correction                          |
| <input type="checkbox"/> Nasal surgery                    |  |

Other interests not listed: \_\_\_\_\_

Which of the above have you already had performed? \_\_\_\_\_

**MEDICAL HISTORY**

Are you taking any drugs, medications or vitamins?  YES  NO If yes, list:  
1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, list:  
1. \_\_\_\_\_ 2. \_\_\_\_\_

Please list all previous surgeries (including cosmetic) and dates?  
1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?  
 YES  NO If bad reaction. describe:

Do you have now, or have ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
<b>Lungs:</b>			<b>Gastrointestinal:</b>		
Asthma or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest x-rays	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal/neurological:</b>		
<b>Cardiovascular:</b>			Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
History of leg swelling	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>			
PACEMAKER/Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Hematologic/metabolic:</b>	<b>YES</b>	<b>NO</b>	<b>Other systemic:</b>	<b>YES</b>	<b>NO</b>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ear disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Nasal/sinus disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

List any other diseases or conditions not covered above:

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**Social History:**

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per week.  
 Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Have you had or have you been exposed to HIV (AIDS)?  YES  NO  
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_\_\_

**Skin:** One of the important parameters for the success of your treatment is the correct typing of your skin. Your doctor will consider your skin type when planning your treatment program for many aesthetic medical procedures. Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your doctor are genetic disposition and reaction to sun exposure and tanning beds.

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color.

Please take a few minutes and complete this questionnaire to help us determine your skin type and treat you the right way.

**GENETIC DISPOSITION:**

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
	< Total score for Genetic Disposition				

**REACTION TO SUN EXPOSURE:**

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark, brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	< Total score for Reaction to Sun Exposure				

**TANNING HABITS:**

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	< Total score for Tanning Habits				

	< Total score for Genetic Disposition
	< Total score for Reaction to Sun Exposure
	< Total score for Tanning Habits

	< SKIN TYPE SCORE
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**FITZPATRICK SKIN TYPE**

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

*The above information is strictly confidential*

Completed by:  Patient

Medical Assistant/RN \_\_\_\_\_  
Initials

\_\_\_\_\_  
Signed by Patient Date

\_\_\_\_\_  
Reviewed by Date

# CEI/CSI/CFI/LTHF

## Patient Service Guidelines

Effective 1/1/2009

**Consent to Treatment:** I voluntarily request and authorize the California Ear Institute, California Sinus Institute, California Face and Laser Institute, and the Let Them Hear Foundation (the “Clinics”) to render care, including diagnostic procedures and medical treatment, by its authorized agents and employees (collectively, “Clinic Personnel”). I acknowledge that no guarantees have been made as to the efficacy of such examination or treatment for my condition, or the condition of the person on whose behalf I am legally authorized to consent to (collectively, the “Patient”). I understand that I have the right to make decisions concerning the Patient’s health care, including the right to authorize or refuse medical and surgical procedures.

**Release of Information:** By signing this document, the Patient is authorizing release of the Patient’s medical records under the following circumstances:

1. To any health, sickness, and accident insurance carrier, workman’s compensation insurers, or any governmental agency which is legally responsible, or which the Clinics have good cause to believe is legally responsible for all or any part of the Clinics charges and/or professional fees.
2. To physicians or health care facilities rendering professional care to the Patient.
3. To any governmental organization responsible for reviewing medical care
4. To Clinic Personnel, from physicians or health care facilities rendering professional care to the Patient

**Cancellation/Missed Appointment Policy:** All patients who fail to arrive for their scheduled appointments or who cancel with less than one business day advance notice will be charged a missed appointment fee. This fee applies to all patients, regardless of their insurance status or insurer.

**Reminder phone calls are a courtesy, and the lack of receipt of a reminder call is not a valid excuse for missed appointments.** Missed appointment fees are NOT covered by insurance, and will be the Patient’s personal responsibility to pay. You will not be able to make future appointments until any outstanding missed appointment fees are paid. Missed appointment fees are as follows:

<b>Hearing Device Center/Vestibular Testing</b>	<b>\$50 for every ½ hour scheduled</b>
<b>LTHF appointments (any type)</b>	<b>\$75 for every ¼ hour scheduled</b>
<b>New Patient Medical Visit (CEI/CSI)</b>	<b>\$150</b>
<b>New Patient Medical Visit (CFI)</b>	<b>\$100</b>
<b>New Patient Non-Physician appointment (any type other than LTHF/HDC/Vestibular)</b>	<b>\$100</b>
<b>All other visits (return medical visit)</b>	<b>\$75</b>

If you miss three appointments, we will cancel any remaining appointments and notify the Patient's referring physician.

**Prior Authorization for Visits to the Clinics:** Patients are responsible for any and all visits to a primary care physician necessary to obtain pre-authorizations for the Patient's regular office visits to the Clinics and associated testing. If the Patient fails to obtain the appropriate authorization and does not cancel the appointment with at least one business day notice, they will be liable for the missed appointment fee as defined above. If the Patient chooses to proceed with the appointment without the authorization, the unauthorized appointment will be treated as cash pay only, and any insurance payment will go to the Patient.

**Payment Guarantee:** Patient agrees to be responsible to the Clinics for all charges resulting from services rendered at their prevailing rates. Patient agrees all bills are due in full upon demand. Should Patient fail to honor this agreement, they agree to pay any collection cost or attorney fees resulting from the collection of my accounts. Patient authorizes the use of all information provided to the Clinics in the Patient Registration form for collection purposes. No granting of extensions or delays on the part of the Clinics in enforcing any of their rights shall in any manner release the undersigned liability. Bad checks will be collected pursuant to California Civil Code § 1719 which allows for up to treble damages.

**Insurer Billing:** The California Ear Institute and California Sinus Institute will bill a primary and a single secondary insurer. Payment responsibility will be transferred to the Patient or Patient's guarantor 90 days after the date of service, regardless of the status of the insurance payment. The Let Them Hear Foundation and the California Face and Laser Institute do not contract with any insurers. Payment for Let Them Hear Foundation and California Face and Laser Institute services is expected the date the service is rendered, and the Patient's primary insurer only will be billed as a courtesy, if applicable.

**Payment Financing:** All costs or fees for treatment or equipment received at the Clinics by Patient through a financing mechanism other than credit cards will be borne by Patient. The use of a financing service by Patient is completely voluntary. Patient acknowledges that fees associated with health care financing services can range from a minimum of five percent to over fourteen percent depending on the amount financed, the length of financing, and the interest rate charged on the financed amount. Patients will receive a 2.5% discount for any payment made to the Clinics for charges related to any service or equipment other than co-pays or deductible made by check, wire transfer, or money order.

**Insurer Denials:** I agree that I will be financially responsible for any services provided to the Patient that any insurer determines to be denied or non-covered for any reason. I consent to Clinic Personnel acting on the Patient's behalf in pursuing any appeals necessary to obtain payment for services where payment is being denied by the insurer. I acknowledge that if Clinic Personnel voluntarily undertake this insurance advocacy on the Patient's behalf that such activities do not constitute legal representation, and that the Patient may retain outside counsel at their own expense to concurrently participate. For Medicare patients, the terms of a valid and fully executed Advanced Benefit Notice will supersede this paragraph.

**Assignment of Benefits:** I hereby assign all rights and privileges and authorize payment directly to the California Ear Institute and California Sinus Institute for any claim filed on the Patient's behalf. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand that I am financially responsible to the Clinics for charges not covered by this assignment or not paid on a timely basis by the insurance company. Because the Let Them Hear Foundation and the California Face and Laser Institute are not contracted with any insurers and require cash payment at the time of service, any amounts paid by the insurer should go directly to the Patient.

**Assistant Surgeon:** For the Patient's benefit, Clinic Personnel may elect to have an assistant surgeon present at the time of surgery. The assistant surgeon may be a physician, physician's assistant, or nurse practitioner. The usual fee for the assistant surgeon is 25 % of the surgeon's fee. Some insurance carriers do not provide benefits for assistant surgeons. If the patient's insurer denies coverage, the fee will be reduced to \$250, but it will be immediately due and payable in full.

**Arbitration:** Any dispute, claim or controversy arising out of or relating to this Agreement or the breach, termination, enforcement, interpretation or validity thereof, other than the collection of an amount due on a returned check, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in Palo Alto, CA, before an arbitrator. The arbitration shall be administered by the American Arbitration Association (AAA) pursuant to the AAA's Rules and Procedures. Judgment on the award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction. The arbitrator may, in the award, allocate all or part of the costs of the arbitration, including the fees of the arbitrator and the reasonable attorneys' fees of the prevailing party.

**Image Recording:** I understand that CEI is a teaching institution, and that my office visits may be recorded and used for training, educational, or publication purposes. This recording will be anonymous and you will not be identified, or identifiable. I hereby release and hold harmless the CEI, its Boards of Directors, officers, administrators, employees, and producers from any and all liability in connection with the production, distribution, and marketing, including but not limited to retail sales of the digital resources, in whatever form and through whatever media. I cede any and all rights, title, and interest in the digital resources to which I may be entitled by law to CEI, and agree to make no claim for compensation for the uses of my image in the production, distribution, marketing, and/or other activities related to the digital resources.

**Non-Discrimination:** The Clinics are committed to operating within California's Unruh Civil Rights Act as applied to business establishments including medical groups. All patients will receive equal treatment and access to facilities and services regardless of their sex, sexual orientation, race, color, religion, ancestry, national origin, disability, or medical condition.

# CEI/CSI/CFI/LTHF

## Email and Telephone Call Policies

Effective 6/9/2008

Electronic mail and telephone calls are becoming a larger part of medical care every year. The American Medical Association has recognized this fact by implementing CPT (billing) codes which allow medical service providers to charge for consultations provided either by telephone or email.

In order for medical service providers at the CEI/CSI/CFI and LTHF to continue to be able to provide optimum medical care for our patients, we must begin charging for these services under some circumstances. You will not be billed for this service if **any** of the following conditions are true:

1. You have had an appointment in the previous week
2. You are scheduling the first available appointment as a result of the email/phone call
3. You have had surgery in the previous 10 days (90 days if a major procedure)
4. You have a fully authorized surgery scheduled for the future
5. You are calling for a prescription refill and you have had an appointment in the past year.

For all other situations, email and phone calls will be billed at the following rates:

<b>99441</b>	5-10 minute phone call, physician	\$50
<b>98966</b>	5-10 minute phone call, other qualified provider	\$20
<b>98967</b>	11-20 minute phone call, other qualified provider	\$40
<b>98968</b>	21-30 minute phone call, other qualified provider	\$60
<b>99444</b>	E-mail response by physician to patient query	\$35
<b>98969</b>	E-mail sent by other qualified provider	\$15

CEI/CSI/LTHF billing staff will submit claims for these services on your behalf to your insurance company. CFI does not submit claims for these services to insurers. Medicare will not reimburse for these services. To determine whether and how much of this charge may be reimbursed by your private insurer, you may call the customer service number on the back of your insurance card, provide them the 5 digit code starting with "9" listed above, and ask them if this code is covered and what your specific financial responsibility will be with respect to this code.

# **CEI / CSI / CFI / LTHF**

## **PATIENT E-MAIL TERMS OF USE**

### **E-MAIL DISCLAIMER**

CEI / CSI / CFI / LTHF (hereinafter “the Clinics”) will use reasonable means to protect the privacy of your health information sent by e-mail. However, because of the risks outlined below, the Clinics cannot guarantee that e-mail communications will be confidential. Additionally, the Clinics will not be liable in the event that you or anyone else inappropriately accesses or uses your e-mail. The Clinics will not be liable for improper disclosure of your health information that is not caused by intentional misconduct.

### **YOUR RESPONSIBILITY TO REDUCE E-MAIL RISKS**

At the discretion of the Clinics, its staff, physicians and agents (“Clinic Personnel”) and upon your agreement to the terms outlined within this consent form, you may use e-mail to communicate with Clinic Personnel. These e-mails may contain your personal health information. If you decide to use e-mail to communicate with Clinic Personnel you should be aware of the following risks and/or your responsibilities:

1. As the Internet is not secure or private, unauthorized people may be able to intercept, read and possibly modify e-mail you send to or are sent by Clinic Personnel.
2. You are responsible for protecting your e-mail account, password and computer against access by unauthorized people.
3. Since e-mail can be used to spread viruses, some which cause e-mail messages to be sent to people who you do not intend to send e-mail messages to, you should install and maintain virus protection software on your PC.
4. Since e-mails can be copied, printed and forwarded by people to whom you send e-mails, you should be careful regarding whom you send e-mails.
5. As your employer may claim ownership of, or the right to access, the e-mail account issued to you by your e-mail, you should avoid using an employer issued e-mail account to communicate with the Clinics.

### **TERMS AND CONDITIONS FOR THE USE OF E-MAIL**

By consenting to the use of e-mail with the Clinics, you agree that:

1. In consideration of being allowed to communicate with Clinic Personnel using e-mail, you agree that the following actions shall constitute a material breach of these Terms and Conditions:
  - a. signing on as or pretending to be another person
  - b. using secure messaging for any purpose in violation of local, state, national, international laws or posted Clinic policies
  - c. transmitting material that infringes or violates the intellectual property rights of others or the privacy or publicity rights of others
  - d. transmitting material that is unlawful, obscene, defamatory, predatory of minors, threatening, harassing, abusive, slanderous, or hateful to any person (including Clinic Personnel) or entity as determined by the Clinics in its sole discretion

- e. using e-mail in a way that is intended to harm, or a reasonable person would understand would likely result in harm, to the user or others
  - f. collecting information about others, including e-mail addresses
  - g. intentionally distributing viruses or other harmful computer code
2. Clinic Personnel expressly reserve the right, in its sole discretion, to terminate your access to e-mail communication due to any act that would constitute a violation of these Terms and Conditions.
  3. Clinic Personnel may forward e-mails as appropriate for diagnosis, treatment, reimbursement, and other related reasons related to your email or the operation of the email system. Your e-mail and our reply will be printed and included as part of your medical record. Therefore, Clinic Personnel, other than your intended recipient, may have access to e-mails that you send. Clinic Personnel will not forward e-mails to independent third parties without your prior written consent, except as authorized or required by law, or for insurance or billing purposes.
  4. Although Clinic Personnel will try to read and respond promptly to your e-mails, this response may not be immediate. Therefore, you should not use e-mail to communicate with the Clinics if there is an emergency or where you require an answer in a short period of time.

**If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital. Do not attempt to access emergency care through e-mail communication with the Clinics or Clinic Personnel.**

5. If your e-mail requires or asks for a response, and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with Clinic Personnel by telephone.
6. You should carefully consider the risk of using e-mail for the communication of sensitive medical information, such as, but not limited to, information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
7. You should carefully word your e-mail messages so the information provided clearly, yet briefly, describes the information you intend to convey. You should avoid writing long "chatty" e-mails.
8. You are responsible for correcting any unclear or incorrect information.
9. It is your responsibility to follow up and/or schedule an appointment if warranted or recommended by Clinic Personnel.
10. E-mails may not be the only form of communication that the Clinics will use to communicate with you. Additionally, Clinic Personnel may decide that it is not in your best interest to continue to communicate with you by e-mail. In such case, the Clinic will notify that it no longer intends to communicate with you by e-mail.



# CALIFORNIA EAR INSTITUTE

San Ramon Palo Alto

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## New Patients and

### Returning Patients whose last visit was before 2/29/08

I acknowledge receipt of and the opportunity to review the following documents pertaining to my visit to the California Ear Institute (CEI) / California Sinus Institute (CSI) / California Face and Laser Institute (CFI) and the Let Them Hear Foundation (LTHF):

- CEI/CSI/CFI/LTHF Patient Service Guidelines (Effective 1/1/2009)
- CEI/CSI/CFI/LTHF Non-Standard Appointment Policy (Effective 3/1/2008)
- CEI/CSI/CFI/LTHF Email and Telephone Call Policies (Effective 3/1/2008)
- CEI/CSI/CFI LTHF Notice of Privacy Practices (Effective 3/1/2008)

I understand that acceptance of the terms contained in each of these documents is a condition of receiving care at CEI/CSI/CFI/LTHF

By signing this document, I attest that all of the information I have provided to CEI/CSI/CFI/LTHF is true to the best of my knowledge, and that I will notify CEI/CSI/CFI/LTHF of any changes.

_____	_____	_____	_____
<b>Patient Signature</b>	<b>Date</b>	<b>Witness</b>	<b>Date</b>

\_\_\_\_\_  
**Title (if signed by someone other than Patient)**

[www.californiaearinstitute.com](http://www.californiaearinstitute.com)