SCOTT M. TAYLOR, MD, APC
400 29th STREET #400
OAKLAND, CA 94609

P: 510.238.9600
F: 510.238.9609

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## WELCOME TO OUR OFFICE!

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**PLEASE BRING THE FOLLOWING ITEMS:**

- ➔ **INSURANCE CARD(S)**
- ➔ **PICTURE ID (a picture will also be taken for identity protection)**
- ➔ **CO-PAY (Due at appointment time. Cash or Credit Card Only – No American Express)**
  **($25 administrative/billing fee if not paid at time of appointment)**
- ➔ **X-RAY Films/CD or MRI Films/CD (if asked to bring by our office)**
  **(Please note that Films or CD are to be hand carried by patient and cannot be mailed)**
- ➔ **LIST OF MEDICATIONS or LIST THEM ON PAGE 3 OF ATTACHED PACKET**
  **(Include strength, quantity of pills per day, condition being treated)**
- ➔ **FILL ATTACHED PACKET IN ITS ENTIRETY BEFORE APPOINTMENT**
  **(The appointment may be delayed if paperwork is not complete upon arrival)**

**PLEASE NOTE: IF THE ABOVE ITEMS ARE NOT BROUGHT TO THE APPOINTMENT, YOU MAY BE RESCHEDULED.**

**PATIENT NAME:** _____

**APPOINTMENT DATE:**_____ **TIME:** _____

**(There will be a $25 fee if appointment is not cancelled prior to 48 hours)**

**DURATION: **1HOUR** PLEASE ARRIVE 15 MINS EARLY FOR REGISTRATION****

****PLEASE BE ADVISED, STREET PARKING ONLY****

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**DATE SENT:** _____

# Scott M. Taylor, M.D.

A Professional Corporation
400 – 29th Street, Suite 400, Oakland, CA 94609

**********

**Please PRINT and complete all sections**

Patient Name: _____
Last Name First Name Middle Initial

Home Address: _____

City: _____ State: _____ Zip Code: _____ Male Female

Date of Birth: _____ Driver License# _____ SS# _____

Hm Ph# _____ Cell Ph# _____ Wk Ph# _____

*E-Mail: _____ Fax# _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Preferred Language _____

Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐African American ☐Caucasian ☐Other _____

Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Hm Ph # _____

Spouse's Employer: _____ Wk Ph # _____

Employer Address: _____

Circle One: Single Married Divorced Widow Separated Domestic Partner

**********

*Name of Insurance _____

*Primary Care Physician: **(MUST PROVIDE):** _____

Address: _____ Ph # _____ Fax # _____

**********

*Pharmacy Name: _____ Ph # _____ Fax # _____

Address: **(MUST PROVIDE):** _____

**********

*Contact in case of emergency: _____

Phone Number: _____ Relationship: _____

**********

I, the above named patient, hereby certify that all of the above information is true and correct. I understand that if the above is not true or if I'm not eligible under the terms of my Medical Insurance Agreement, I am liable for all charges for services rendered. I authorize my Insurance Company to pay benefits directly to Dr. Scott M. Taylor, and I authorize Scott M. Taylor, M.D., to release any information required to process this claim.
I understand that all payments (medical services, co-pays, deductibles, and deposits) are due at the time of the service.
Cash and credit cards are acceptable methods of payment. **I also understand that I will be responsible to pay a $25.00 charge due to all missed appointments which are not canceled 24 hours in advance.** **THIS RULE IS STRICTLY ENFORCED!**

NOTICE TO CONSUMERS: MEDICAL DOCTORS ARE LICENSED AND REGULATED BY THE MEDICAL BOARD OF CALIFORNIA, (800) 633-2322, www.mbc.ca.gov.

_____ _____
Patient's Signature Date

Name: _____ Height: _____ Weight: _____ Age: _____

❑ Right Handed ❑ Left Handed ❑ Ambidextrous Date of Evaluation: _____

History Taken By (if other than patient): _____ Relationship to patient: _____

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Do you have an attorney? ❑ Yes ❑ No -- If "yes", name of attorney: _____

Address: _____ Phone#: _____ Fax#: _____

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## History of Injury

Date of Injury: _____ Time of Injury: _____

Body part(s) injured (Include right and/or left): _____

How did the injury occur? (Please be specific): _____

_____

_____

Was the pain immediate? ❑ Yes ❑ No -- If "no", when did the pain start? _____

Did you report the injury to your employer/supervisor? ❑ Yes ❑ No -- If "yes", when? _____

Name of the person whom you reported the injury: _____ His/Her Title: _____

Have you been determined to be permanent and stationary (QME)? ❑ Yes ❑ No

If "yes", name of doctor: _____ Date of P&S: _____

### History of Prior or Re-injuries

Have you had any <u>previous</u> injuries to the body part(s) on your claim? ❑ Yes ❑ No

If "yes", describe previous injuries (How were you injured? When? Treatment(s)? Was it resolved?): _____

_____

_____

Have you <u>reinjured</u> the body part(s) described in your claim since the date of injury? ❑ Yes ❑ No

If "yes", please describe re-injuries (What happened? When?): _____

_____

_____

**********

## Employment History

Employer (at time of injury): _____

Job Title: _____ When did you first start working for this company: _____

Hours worked each day_____ Hours worked each week_____ Overtime (hours per week)_____

Describe your job duties: _____

_____

How long have you done this type of work: _____ Did you miss time from work following this injury? ❑ Yes ❑ No

Date(s) you were off work due to these injur(ies): _____

Are you working now? ❑ Yes ❑ No -- If "yes": ❑ Regular duty ❑ Modified duty

If modified, please describe modifications/restrictions: _____

_____

If you are not working now, would you like to return to the job you had at the time of your injury? ❑ Yes ❑ No

If not, why not? _____

Have you had any additional employment since the injury? ❑ Yes ❑ No -- If "yes", employer: _____

Job Duties: _____

## Treatment History

Date of First Treatment: _____ Name of First Treating Physician: _____

Name of Facility: _____ Initial Diagnosis: _____

Were there any work restrictions from the first doctor's visit? ❑ Yes ❑ No

If "yes", what restrictions: _____

Please describe all treatment(s) you have had for this injury: (Examples: X-Ray, MRI, Nerve Study(EMG/NCV), Physical Therapy, Cortisone Injection, etc)

| Doctor / Facility | Treatment(s) | Date(s) |
|---|---|---|
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**CURRENT** Primary Treating Physician (doctor treating you now): _____

Address: _____ Specialty: _____

**********

## Past Medical History

### Surgeries

| Body Part(s) | Surgical Procedure | Date(s) | Hospital / Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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### Serious Non-Surgical Injuries (Examples: Fractures, Sprains, Dislocation, etc)

| Body Part(s) | Type of Injury | Date(s) | Treatment Received |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

### Major Medical Illnesses (please check all that apply)

❑ Tuberculosis ❑ Epilepsy ❑ Diabetes ❑ Mental Illness ❑ Asthma ❑ Arthritis ❑ Gout ❑ High Blood Pressure

❑ Migraines ❑ High Cholesterol ❑ Spinal Disorder ❑ Heart Attack ❑ Kidney Disease ❑ Cancer (what type?):_____

❑ Other Illnesses: _____

### Family History

❑ Tuberculosis ❑ Epilepsy ❑ Diabetes ❑ Mental Illness ❑ Asthma ❑ Arthritis ❑ Gout ❑ High Blood Pressure

❑ Migraines ❑ High Cholesterol ❑ Spinal Disorder ❑ Heart Attack ❑ Kidney Disease ❑ Cancer (what type?):_____

❑ Other Illnesses: _____

## Current Complaints

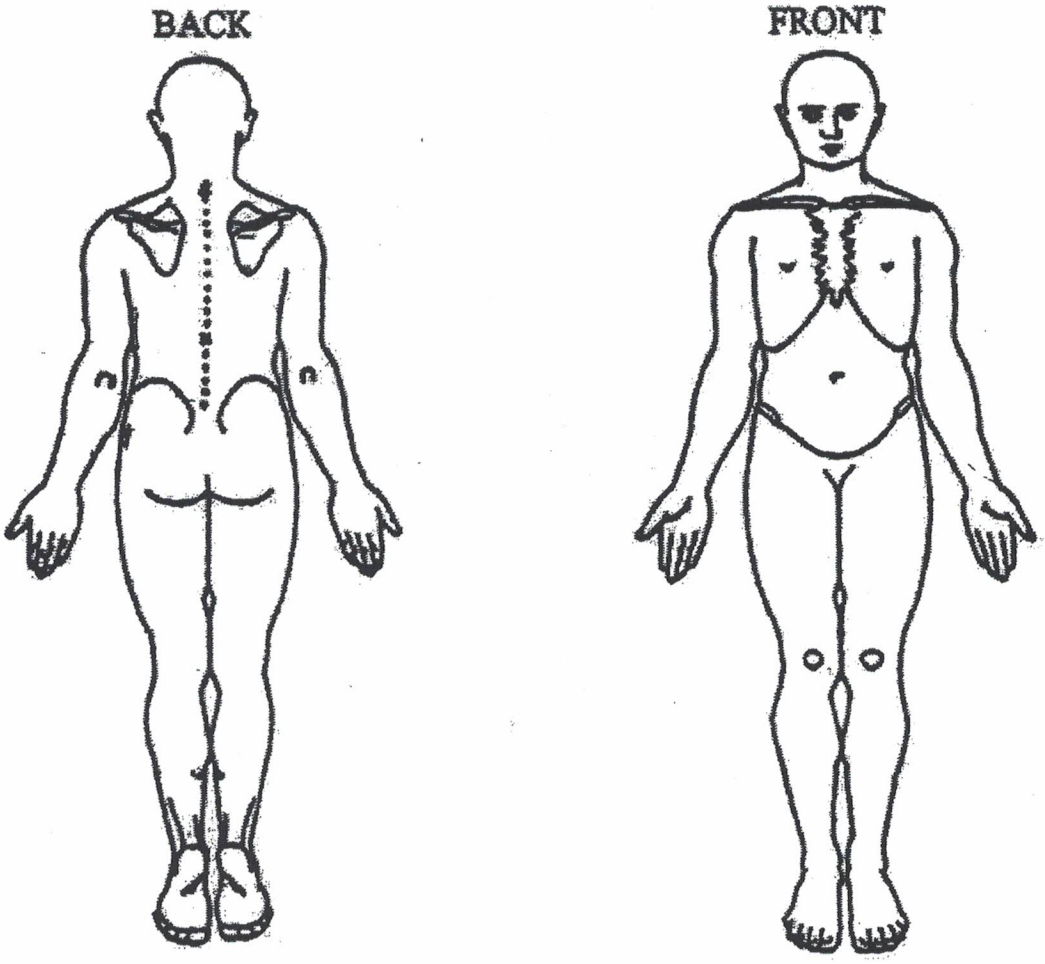
Describe your current pain symptoms/current complaints: _____

_____

**PAIN BODY DIAGRAM**

Be sure to TAKE YOUR TIME and mark these drawings (front and back of your body) EXTREMELY ACCURATELY. Mark all the areas of your body where you feel the sensation described. Use the appropriate symbol. Mark the areas of radiation (where pain continues from one part of the body, where it originates, to another). Once again, include all affected areas, front and back.

| | | |
|---|---|---|
| Numbness ======= | Pins & Needles 0000000 | Burning Pain xxxxxxx |
| Stabbing Pain ///////// | Aching Pain (((((((((( | |




**PLEASE COMPLETE FOR YOUR PAIN TODAY**

Please circle one number IN EACH LINE: 0 = no pain at all, 10 = most intense pain

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Right now | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At its worst | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At its best | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

What makes the pain better?_____

What makes the pain worse?_____

Does the pain wake you up from sleep? ❑ Yes ❑ No

## Social History

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow ❑ Separated ❑ Domestic Partner ❑ Other: _____

Number of Children: _____ Children at Home: _____

Do you smoke? ❑ Yes ❑ No -- ❑ Cigarettes ❑ Cigars -- Quantity per day: _____

Are you a previous smoker? ❑ Yes ❑ No -- if "yes", When did you quit: _____

Do you consume alcohol? ❑ Yes ❑ No -- ❑ Hard Liquor ❑ Wine ❑ Beer -- Quantity per day: _____

Do you use recreational drug? ❑ Yes ❑ No -- if "yes", Description of use: _____

Where were you born (city, state, country)? _____

If not born in US, when did you move here? _____

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## Allergies ❑ No Known Allergies

| Name of Medication you are allergic to | Reactions (Examples: Hives, Swelling, Rash, Childhood Allergy, etc) |
|---|---|
| | |
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## Prescribed Medications (currently taking) ❑ None

| Name of Medication | Strength | Times per Day | Condition Being Treated |
|---|---|---|---|
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## Over the Counter Drugs (currently taking) ❑ None

| Name of Medication | Strength | Times per Day | Condition Being Treated |
|---|---|---|---|
| | | | |
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**Scott M. Taylor, M.D.**
**A Professional Corporation**
400 - 29th Street, Suite 400
Oakland, CA 94609
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# Acknowledgment of Receipt of Notice of Privacy Practices

Name of Patient:_____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at every appointment.

_____ _____
Signature Date

_____ _____
Print Name Telephone Number

If not signed by the patient, please indicate your relationship to the patient.

❑ Parent or guardian of minor patient.
❑ Guarantor or conservator of incompetent patient.

Scott M. Taylor, M.D.
A Professional Corporation
400-29th Street, Suite 400
Oakland CA 94609
(510) 238-9600 • (510 238-9609 fax

# 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 REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operation and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your protected health information means any of your written and oral health information, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health condition.

I. Uses and Disclosures or protected Health Information

Scott M. Taylor, M.D., A Professional Corporation (The Corporation), may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting health-care operations. Your protected health information may be used or disclosed only for these purposes unless The Corporation has obtained your authorization or the use or disclosure is otherwise permitted by the HIPPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For instance, we may disclose your protected health information to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose protected health information to other physicians who may be treating you or consulting with your physician with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the health plan. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or, as requir4ed by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care of the other provider's payment activities.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of the provider and to provide quality care to all patients. Health care operations include such activities as:

- Quality assessment and improvement activities
- Employee review activities
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision
- Accreditation, certification, licensing or credentialing activities
- Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs
- Business management and general administrative activities

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and healthcare operations, we may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment
- To inform you of potential treatment alternatives or options
- To inform you of health-related benefits or services that may be of interest to you
- To contact you to raise funds for the provider or an institutional foundation related to the provider. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object. Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information without your permission when we are required to do so by any Federal, Stat4e or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law
- To report vital events such as birth or death as permitted or required by law
- To conduct public health surveillance, investigations and interventions as permitted or required by law
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading disease as authorized by law
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required

C. To Report Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities including audits, civil, administrative, or criminal investigations, proceedings, or actions, inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena in some circumstances.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- Under certain limited circumstances, when you are a victim of a crime
- To a law enforcement official if the provider has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of A Serious Threat To Health Or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, the Federal regulations authorize the provider to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. The provider may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted Without Authorization But With Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death. You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize. Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon authorities.

V. Your Rights. You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that your physician and the provider uses for making decisions about you. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision. To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last pages of this Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have any questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purpose of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. The Corporation is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If The Corporation does not agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive a confidential communication from us by alternative means or at an alternative location. You have the right to request that we communicate to you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to have your physician amend your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by The Corporation. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing in our Privacy Officer. The request should specify the time period sought for the accounting. We are not requir4ed to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this Notice. Upon request, we will provide a separate paper copy of this Notice even if you have already received a copy of the Notice or have agreed to accept this Notice electronically.

VI. Our Duties

The Corporation is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that we maintain. If the provider changes its Notice, we will provide a copy of the revised Notice by sending a copy of the Revised Notice via regular mail or through in-person contact.

VII. Complaints

You have the right to express complaints to The Corporation and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to The Corporation by contacting the provider's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The Corporation's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to the Privacy Officer by sending them to:

Scott M. Taylor, M.D.
A Professional Corporation
400-29th Street, Suite 400
Oakland CA 94609
ATTN: PRIVACY OFFICER

The Privacy Officer can be contacted by telephone at 510-238-9600

IX. Effective Date

This Notice is effective November 1, 2007.