Jonah Medical Group · Nanoom Medical Group

REGISTRATION FORM

Patient Last Name, First Name	Age	Date of Birth	☐ Male ☐ Female
Address, City, State, Zip			
Mailing Address City, State, Zip ☐ *Same as above*			

Home Phone	Cell Phone	Email	Social Security Number

ADDITIONAL INFORMATION

Pharmacy History Consent ☐Yes ☐ No	Ethnicity	Consent to Receive Calls ☐ Yes ☐ No
Pharmacy Name, Phone, Fax		Consent to Receive Texts ☐ Yes ☐ No
Previous Primary Care Physician Name, Phone, Fax		

EMERGENCY CONTACT INFORMATION

Last Name, First	Relationship to Patient	Phone Number

HEALTH INSURANCE INFORMATION

Name	ID Number	Phone Number

AUTHORIZATION

I hereby authorize the providers of Jonah Medical Group to be attending physicians and to administer to me any examination, treatment and medications he/she deems therapeutic to my presenting complaint. I hereby authorize Jonah Medical Group to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the providers all payments for medical services.

_____

Patient Name (PRINT) / Sign / Date

_____

Parent/Guardian Name (PRINT) / Sign / Date

PATIENT NAME (PRINT):_____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION
(Request Records)

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

I hereby authorize: _____
Provider/Healthcare Facility

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

The medical information/records will be used for the following purpose:

_____

To: Jonah Medical Group dba Nanoom Medical Group (Phone: 800-821-5675)

☐ LA Jonah	Fax: 213-388-5154	3663 W 6th St #103 Los Angeles, CA 90020
☐ LA Westmoreland	Fax: 213-315-5195	866 Westmoreland Blvd #101 Los Angeles, CA 90005
☐ Anaheim	Fax: 714-484-3852	408 S Beach Blvd #204 Anaheim, CA 92804
☐ Diamond Bar	Fax: 909-480-0201	20627 Golden Springs Dr #1B Diamond Bar, CA 91789
☐ Victorville	Fax: 760-552-4472	15095 Amargosa Drive, #102 Victorville, CA 92394

This authorization is:

☐ Unlimited (All records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information:

_____

I also consent to release of the following records (please initial):

_____Drug/Alcohol/Substance Abuse ___Psychiatric/Mental Health _____Antibodies to HIV

_____HIV Diagnosis/Treatment ___Genetic Information

DURATION

This authorization shall be effective immediately and remain in effect until:_____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____

Patient's Name (PRINT) / Signature / Date

_____

Parent/Guardian Name (PRINT) / Signature / Date

_____

Patient's Social Security Number

_____

Patient's Date of Birth

_____

Witness Name (PRINT) / Signature / Date

Jonah Medical Group · Nanoom Medical Group

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION (RELEASE RECORDS)

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

I hereby authorize the following physician(s):

☐ Edwin Choi MD ☐ Jun Chung MD ☐ Daesoon Leem MD ☐ Eun Shin MD

to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax, or other electronic methods.

The medical information/records will be used for the following purpose:

_____

This authorization is:

☐ Unlimited
(All records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information:

_____

DURATION

This authorization shall be effective immediately and remain in effect until: _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____
Patient's Name (PRINT) / Signature / Date

_____
Parent/Guardian Name (PRINT) / Signature / Date

_____
Patient's Social Security Number

_____
Patient's Date of Birth

_____
Witness Name (PRINT) / Signature / Date

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For questions, please contact Jonah Medical Group · Nanoom Medical Group at (800) 821-5675.

Jonah Medical Group · Nanoom Medical Group

AUTHORIZATION TO RELEASE INFORMATION

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, by checking the box below. Please be sure to validate your request by printing and signing your name below.

☐ **Do not release any information.**

I authorize Jonah Medical Group · Nanoom Medical Group to release my records and any information requested to the following individuals:

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

_____
Patient Name (PRINT) / Signature / Date

_____
Parent/Guardian Name (PRINT) / Signature / Date

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Please review it carefully.

- **Get an electronic or paper copy of your medical record**
  - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
  - We will provide a copy or a summary of your health information, usually within 30 days of your request.
  - We may charge a reasonable, cost-based fee.

- **Request confidential communication**
  - You can ask us to contact you in a specific way for example, home, office, cell phone, or email.
  - We will say "yes" to all reasonable requests.

- **Ask us to limit what we use or share**
  - You can ask us not to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
  - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

- **Get a list of those with whom we've shared information**
    - You can ask for a list (accounting) of the times we've shared your health information for 6 years prior to the date you ask, who we shared it with, and why.
    - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures you may have requested.
    - We'll provide 1 year of accounting for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
    - We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research.
    - We must meet many conditions by law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- **Get a copy of this privacy notice**
    - You can ask for a paper copy of this notice at any time, even if you have opted to receive it electronically.

- **Choose someone to act for you**
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    - We will verify that the appointed person has this authority and can act on your behalf.

- **File a complaint if you feel your rights are violated**
    - You can complain if you feel we have violated your rights by contacting us using the information on page 1.
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 202021, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.
    - We will not retaliate against you for filing a complaint.

- **How do we typically use or share your health information?**
    - We typically use or share your health information in the following ways:

- **Treat you**
    - We can use your health information and share it with other professionals who are treating you.

Example: A doctor treat you for an injury asks another doctor about your overall health condition.

- **Run our organization**
    - We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

- **Bill for your services**
    - We can use and share your health information to bill and get payment from health plans or other entities.

- **Help with public health and safety issues**

We can share health information about you in certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

- **Do research**
    - We can use or share your information for health research purposes.

- **Comply with the law**
    - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

- **Respond to organ and tissue donation requests**

  We can share health information about you with organ procurement organizations.

- **Work with a medical examiner or funeral director**

  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests**

  We can use or share health information about you:

  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions**

  - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Jonah Medical Group, Inc. has offered to communicate with Patient and/or Parent/Guardian using the following means of electronic communication [please check all that apply]:

☐ Email

☐ Text

☐ Video

☐ Patient Portal

☐ Other (please specify): _____

Jonah Medical Group, Inc. will use reasonable means to protect the security and confidentiality of information sent and received using these methods. The Physician cannot guarantee the security and confidentiality of electronic communications, however, please know Jonah Medical Group abides by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HIPAA Privacy Rules as provided by the Centers for Disease Control and Prevention.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communication method(s) as outlined in Appendix A.

I consent to the conditions and will follow the instructions outlined in the Appendix A, as well as any other conditions that the Physician or Physician's staff may impose on communications with patients using such method(s).

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using these methods may not be encrypted.

Despite this, I agree to communicate with the Physician or the Physician's staff using these methods with a full understanding of the risk.

I acknowledge that either I, the Physician, or Physician's staff may at any time withdraw the option of communicating electronically through these methods upon providing verbal/written notice.

Should you have any questions or concerns, please address them to the Physician or the Physician's staff before signing below.

_____
Patient Address

_____
Patient Email

_____
Patient Home Phone

_____
Patient mobile Phone

_____
Patient Name (Print) / Sign, Date

_____
Parent/Guardian Name (Print) / Sign, Date

PATIENT PHOTO ATTESTATION

This form seeks for the consent for photographs to be taken by Jonah Medical Group (Nanoom Medical Group) through a doctor or a representative.

By signing this form, the patient affirms that the images may be used for the purpose of electronic medical records to ensure proper identification.

You agree that you will not receive any form of compensation in cash or in kind.

Your refusal to consent to the release of your photographs will not, in any way affect the medical care you will receive.

Permission for further use or disclosure of this information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I authorize the use of Photographs for the following: ☐ Accept ☐ Decline

_____
Patient's Name (PRINT) / Signature / Date

_____
Parent/Guardian Name (PRINT) / Signature / Date

_____
Patient's Social Security Number

_____
Patient's Date of Birth

_____
Witness Name (PRINT) / Signature / Date

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