Samantha Von Ins, MD
431 S. Batavia Street, Suite 202, Orange, CA 92868

New Patient Information

Today's Date: ____________________ Home Phone #:(____) __________________

Social Security #: ____

Name: ____ Birthdate: ____ /____ / ____

Last **First** **MI**

Nickname: __________________ _______ ☐ Male ☐ Female

Home Address: ____

____

Who may we thank for referring you?____

What is the reason for today's visit?____

Insurance Information

Primary Insurance:

Insurance Co. Name: ____

Phone #: (____) __________________________

Subscriber#: ______________________________

Group #: ____

Insurance Co. Address:

____

Insured's Name and Date of Birth:

____

Communication Authorization

I agree to send & receive text message correspondence via secured text messaging portal. I also agree to send & receive email correspondence via secured e-mail messaging.

Signature & Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I authorize the Prosperite Health to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature & Date

Samantha Von Ins, MD
431 S. Batavia Street, Suite 202, Orange, CA 92868

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA). I understand that this information can an will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

______________________________	______________________________
Print Patient's Name	Date
______________________________	______________________________
Signature/Relationship to Patient	Print Your Name

Media Release

I hereby consent for Prosperite Health to use, reproduce, exhibit or distribute (in full or in part) any photograph, video, film, and/or audio recordings made of me and my likeness; and/or any written extract of such recordings in which I may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Prosperite Health and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Patient Name:

____

Signature: ____

Date: ______________________

Address: ____

City: __________ State: __________ Zip: ____________________

T 949 438 8312 F 970 788 1822 drsamantha@prosperitehealth.com

DIRECT PRIMARY CARE PATIENT AGREEMENT

The patient-physician relationship is of utmost importance to us, and we thank you for entrusting us with your health care. Communication is at the center of our care, and this Agreement explains how we will work together.

This Agreement is made between Prosperite Health, a California Professional Medical Corporation ("Practice"), and You ("You" or "Patient"). The Practice offers family medicine in exchange for certain fees paid by You according to the terms and conditions described below.

AGREEMENT

Patient. As used in this Agreement, the term Patient means a person for whom Practice will provide Services. Practice reserves the right to accept or decline patients based upon our capability to appropriately manage the primary care needs of our patients.

Services. As used in this Agreement, the term Services means primary care services and certain amenities (collectively "Services"), which are offered by Practice.

Volume of Services. The number of in-person and virtual visits you may receive is not limited by this Agreement.

Availability. Practice will make every effort to address Your medical needs in a timely manner, but we cannot guarantee availability, and we cannot guarantee that You will not need to seek treatment in an urgent care or emergency department setting.

Included Services.

Your membership includes primary care, including well and sick care, and basic gynecological services.

Some services available in our office, such as EKGs, are available at no additional cost to you.

Some services, such as minor surgery, are available in our office and incur an additional fee ("Itemized Charges").

Excluded Services. You may need to use the care of specialists (e.g., obstetrician, cardiologist, pulmonologist, etc.), emergency rooms, and urgent care centers that are outside the scope of this Agreement. Physicians within Practice will make an appropriate determination about the scope of primary care services offered by Practice on a case-by-case basis.

Ancillary Services. Ancillary Services are also Excluded Services. Examples of Ancillary Services include laboratory testing, radiologic testing, pathology studies,

surgery and specialist consultations, and dispensed medications, including but not limited to vaccinations. If you maintain health insurance (which we highly recommend), it may or may not cover the costs of these services. Practice will endeavor to place orders for Ancillary Services in a manner that is cost effective for you.

Controlled Substances. It is not the policy of Practice to Practice to prescribe chronic controlled substances on Your behalf, including commonly abused opioid medications, benzodiazepines, and other stimulants.

After-Hours Visits & Out of Office Visits. Subject to the availability of our Physicians, we offer after-hours and out-of-office visits within a radius of ten (10) miles of Practice for an additional fee of $100 per visit. There is no guarantee of after-hours or out-of-office availability.

Consent to Treat. You acknowledge and hereby authorize Practice to use and/or disclose Your health information which specifically identifies You, or which can reasonably be used to identify You, to carry out Your treatment, payment and healthcare operations. Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the administration and use of prescribed medication, the performance of such procedures as may be deemed necessary or advisable in the treatment of the member, including but not limited to: diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which in the judgment of the attending physician or their assigned designees may be considered medically necessary or advisable.

Scheduling.

In order to best serve the needs of all our patients, we prefer that you schedule Your visit more than 24 hours in advance when possible.

Missed Appointments. We kindly request that you provide us with a minimum of 24 hours notice if you are unable to attend a scheduled appointment. Your advance notice helps us provide the best possible experience for all of our patients.

Fees. In exchange for Services, You agree to pay Practice a) the Monthly Fee; b) the Enrollment Fee; and c) any additional Itemized Charges (collectively “Fees”).

Monthly Fee. Your Monthly Fee is based on your age and identified in the chart below. This fee is for primary care provided by Practice in the month for which the fee was received. Your monthly fee is due no later than the last day of the month and is payable by automatic debit from your bank or credit card account.

Age	Monthly Fee
Dependent under age 18*	$20.80 (discounted to $20 if paid with ACH account) *With the membership of at least one parent or legal guardian.
Ages 0 and up	$103.50 (discounted to $99 if paid with ACH account)

T 949 438 8312 F 970 788 1822 drsamantha@prosperitehealth.com

Enrollment Fee. Your Enrollment Fee is $149 per individual. If you are enrolling your immediate family, your Enrollment Fee is capped at $199.

This fee covers the initial administrative cost of your membership and is not related to the provision of Services. This fee is payable upon execution of this Agreement and is no longer refundable either five (5) business days after You sign it, or as soon as you receive Services, whichever occurs first.

Itemized Charges. The fee for Itemized Charges changes in response to our costs and we endeavor to make these services as affordable as possible. You will be made aware of the fees for these services in advance of the services being performed. Payment for these services is due at the time services are rendered.

Disclaimer of Non-Insurance. **Fees paid are not health insurance.** You acknowledge and understand that this Agreement is not a health insurance plan, and not a substitute for health insurance or other health plan coverage, such as participation in a Health Management Organization ("HMO"). This Agreement is solely for primary care services provided directly to You by Practice. **This Agreement does not cover hospital, specialist, or any services not directly provided by Practice.** It is highly recommended that You maintain health insurance for care you may need that is not part of our Services.

Non-Participation in Health Insurance. You acknowledge that neither Practice, nor the Physician(s) participate in **any** public or private health insurance or HMO plans, including Medicare and Medi-Cal (California's Medicaid program). Neither Practice nor its Physician(s) make any representations regarding third party insurance reimbursement of fees paid under this Agreement, and such reimbursement is not anticipated by this Agreement.

Non-Participation in Medicare. You specifically acknowledge that pursuant to federal regulations, Practice and its Physician(s) have elected "opt out" status of Medicare participation. This means that Medicare cannot be billed for **any** Services performed under this Agreement. Further, You agree not to bill Medicare or attempt Medicare reimbursement for any such services.

If You are eligible for Medicare, or during the term of this Agreement You become eligible for Medicare, then Practice is required to obtain Your understanding, memorialized by Your signature, of our Private Contract & Voluntary Advance Beneficiary Notice of Non-Covered Services ("ABN"). If You are (or become) Medicare eligible and choose not to sign our ABN, your membership will be automatically terminated and any unearned Monthly Fee will be refunded to You.

Term. This Agreement will commence on the date it is signed by the parties and shall have an initial term of one (1) month. Upon the expiration of the initial term this Agreement shall automatically renew for successive monthly terms upon the payment of the Monthly Fee, until the Agreement is terminated pursuant to the terms of Section 10.

Termination. Both You and Practice shall have the absolute and unconditional right to terminate the Agreement, without cause.

While we value Your membership, You are under no obligation to continue receiving Services and You may terminate this Agreement, in writing, at any time.

If you terminate your membership before the end of the month, Your bill will be prorated based upon the number of days membership was provided to You, plus any additional Itemized Charges incurred.

Notwithstanding any other provision of this Agreement, if your decision to terminate is based on a grievance with Practice, You will give us an opportunity to make it right, prior to issuing Your written notice of termination or taking other action.

If Practice elects to terminate this Agreement, Practice will provide You thirty (30) days written notice, or any such other time necessary to transition Your care to another provider.

Practice has a right to determine whom to accept as a patient, just as You have the right to choose Your physician. There are certain circumstances in which we may choose to terminate this Agreement. Such circumstances may include, but are not limited to the following:

You fail to pay fees and charges when they are due.

You fail to sign our ABN, as applicable.

You have performed an act that constitutes fraud.

You fail to adhere to the recommended treatment plan, especially regarding the use of controlled substances.

You are disruptive, abusive, or present an emotional or physical danger to the staff or other patients of Practice.

Practice discontinues operation.

Re-Enrollment. If You choose to discontinue Your membership and You later wish to re-enroll, Practice reserves the right to decline re-enrollment or require You to pay a re-enrollment fee that is equivalent to the months of absent payments while You were not enrolled with Practice, not to exceed twelve (12) months.

Privacy & Communications.

Limited Disclosure. Practice will not disclose your Protected Health Information (“PHI”) for reasons unrelated to the delivery of Services, or the provision of other health care services on Your behalf.

Your Privacy Rights. Practice will adhere to its obligations regarding your privacy rights as identified in Practice’s Patient Notice of Privacy Practices.

Methods of Communication. You acknowledge that Practice communications may include e-mail, facsimile, video chat, instant messaging, and cell phone, and

such communications by their nature cannot be guaranteed to be secure or confidential. If You initiate a conversation in which You disclose PHI on any of these communication platforms, then You authorize Practice to communicate with You regarding all PHI in the same format.

Miscellaneous.

Amendment. No amendment or variation of the terms of this Agreement shall be valid unless in writing and signed by both Parties.

Anti-Referral Laws. Nothing in this Agreement, nor any other written or oral agreement, nor any consideration in connection with this Agreement, contemplates or requires or is intended to induce or influence the admission or referral of any patient to or the generation of any business between Practice and any other person or entity. This Agreement is not intended to influence any Physician's professional judgment in choosing the appropriate care and treatment of patients.

Assignment. This Agreement, and any rights You may have under it, are not assignable or transferable by You.

Authorization for Agreement. The execution and performance of this Agreement by Practice and You have been duly authorized by all necessary laws, resolutions, and corporate or partnership action, and this Agreement constitutes the valid and enforceable obligations of the parties in accordance with its terms.

Captions and Headings. The captions and headings for each provision of this Agreement are included for convenience of reference only and are not to be considered a part hereof, and shall not be deemed to modify, restrict or enlarge any of the terms or provisions of this Agreement.

Entire Agreement. This Agreement constitutes the entire agreement between the Parties with respect to the subject matter hereof, and supersedes any and all other agreements, understandings, negotiations, or representations, oral or written, between them.

Governing Law. This Agreement shall be subject to and governed by the laws of California, without regard to any conflicts of law provisions therein contained. All disputes arising out of this Agreement shall be settled by binding arbitration. The provider of arbitration services shall be made solely at Practice's discretion and costs of arbitration shall be borne equally by the parties.

No Waiver. No waiver of a breach of any provision of this Agreement will be construed to be a waiver of this Agreement, whether of a similar or different nature, and no delay in acting with regard to a breach shall be construed as a waiver of that breach.

Non-Discrimination. Under no circumstances will Practice discriminate against You, or terminate this Agreement, on the basis of sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital

status, sexual orientation, citizenship, primary language, immigration status, or any other protected status.

Notices. Any notices or payments required or permitted to be given under this Agreement shall be deemed given when in writing, by electronic transmission, hand delivered, or with proof of deposit in the United States mail. All notices shall be deemed delivered on the date of actual delivery, as evidenced by the return receipt or courier record, or by verified digital date stamp in the case of electronic transmission.

Severability. If any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and the offending provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

If this Agreement is held to be invalid for unenforceable for any reason, and if Practice is therefore required to refund all or any portion of the Monthly Fees paid by You, You agree to pay Practice an amount equal to the fair market value of the Services actually rendered to You during the period of time for which the refunded fees were paid commensurate with prevailing rates in Orange County, California.

Survival. Any provisions of this Agreement creating obligations extending beyond the term of this Agreement shall survive the expiration or termination of this Agreement, regardless of the reason for such termination.

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[SIGNATURE PAGE TO FOLLOW]

PATIENT ACKNOWLEDGEMENTS

Please read each line carefully and initial to indicate your agreement with the statement.

_____You acknowledge that Practice has advised You to maintain health insurance for coverage of all Services not specifically provided for in this Agreement and You further acknowledge that this agreement is not a contract that provides health insurance.

_____You acknowledge that You do not expect Practice to file or issue any third party insurance claims on Your behalf.

_____You acknowledge that Practice and its Physician(s) have elected "opt out" status of Medicare participation.

_____You acknowledge that You do not have an emergent medical problem at this time.

_____In the event of a medical emergency, You agree to call 911 first.

_____You acknowledge that You do not expect Practice to prescribe chronic controlled substances on Your behalf. You understand that this includes commonly abused opioid medications, benzodiazepines, and other stimulants.

IN WITNESS WHEREOF, the Parties hereto or their duly authorized representatives have executed this Agreement as of the Effective Date first written below.

Printed Name of Patient: ____

____

Signature of Patient/Parent/Legal Guardian/Authorized Representative Date