CAREY B. STROM, M.D.
8631 West 3rd Street, Ste. 1017E, Los Angeles, CA 90048

WELCOME TO OUR OFFICE!

We are delighted that you chose our office for your health care needs, and we appreciate the opportunity to take care of you.

To streamline your visit, please complete the attached paperwork and email or fax back to our office prior to your scheduled appointment.

Email: info@doctorstrom.com

Fax: 310-285-0482

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Insurance Information

Primary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Primary Insurance Claim Address

Secondary Insurance	Code	Subscriber ID#	Phone Number

Effective Date	Subscriber Name & Date of Birth	Group#	Group Name

Secondary Insurance Claim Address

Third Party Billing (Or Remarks)

Street Address	City, State	Zip Code

- AUTHORIZATION TO PAY -

I hereby authorize my insurance provider to pay the physician responsible for my care directly. **I understand that Carey B. Strom, M.D. is not a contracted provider of any insurance policies other than Medicare, but as a courtesy will bill my insurance for the out of network benefits where applicable** and authorize the release of my medical records to my third party payer in order to obtain payment. I fully understand that my insurance may not cover all of the charges and that I am responsible for payment of my account. In the event that my insurance policy issues payment to me, I agree to forward full payment to the rendering physician immediately. I further understand that in the event that my account remains unpaid after 120 days it will be subject to a 6% interest charge. Please be advised that we will attempt to get your procedure pre-certified but it is ultimately your responsibility.

SIGNATURE: ______________________________ **DATE:** ________________

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NOTICE OF PRIVACY PRACTICES

To Our Patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We shall only make disclosures to a person or organization able to help prevent a threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Office Manager.

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4. You may ask us to amend your health information if you believe it is incorrect or incomplete and as long as the information is kept for or by our practice. To request an amendment, your request must be in writing and submitted to the Office Manager. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice, or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager.

8. Our office will make every attempt to get authorization for your procedure but it is ultimately your responsibility.

9. Telemedicine visits are to be billed at customary rates.

10. I agree to use of Command Health's transcription services to transcribe pathology and operative reports.

I, hereby acknowledge that I have been presented with a copy of Carey B. Strom, M.D., Notice of Privacy Practices.

Signature ____

Print Name ____

Date ____

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

HOME TELEPHONE #____
_______Ok to leave message with detailed information
_______Leave message with call back number only

WORK TELEPHONE #____
_______Ok to leave message with detailed information
_______Leave message with call back number only

CELLULAR TELEPHONE #____________________________________
_______Ok to leave message with detailed information
_______Leave message with call back number only
_______Ok to text message

WRITTEN COMMUNICATION
_______Ok to mail to my home address
_______Ok to mail to my work/office address
_______Ok to fax to this number__________________________________

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, PLEASE LIST THE NAMES OF THOSE INDIVIDUALS HERE:

____
____
____
____

OTHER INSTRUCTIONS____
____
____

Patient Signature_________________________________Date__________________

Print Name_____________________________________Date of Birth____________

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310-550-0400
310-285-0482 Fax
www.doctorstrom.com

MEDICAL RECORD RELEASE AUTHORIZATION

TO:____
(DOCTOR/OFFICE/HOSPITAL)

____
(ADDRESS/FAX NUMBER)

I, * ________________________ give my authorization to release all my medical records to the following person:

Carey B. Strom, M.D., FASGE
8631 West 3rd Street, Ste. 1017E,
Los Angeles, CA 90048
Or
Fax to office at 310-285-0482

*Name of patient____

*Address____

*Birthdate_______________________________

*Signature_______________________________

*Date__________________________________

***Fill these sections only**

CAREY B. STROM, M.D.

8631 West 3RD Street, Suite 1017E
Los Angeles, CA 90048
T: 310 550-0400

Telehealth Informed Consent

Tele-health is healthcare provided by any means other than face to face visit. It is certainly a major convenience, especially since it was implemented during the COVID-19 pandemic. Most patients find it very convenient to talk to their doctor without leaving their home through telephone conversation, video conferencing, such as with Skype, FaceTime, Zoom, or other similar services. However, I realize that they may not provide a secure HIPAA compliant platform.

I understand that tele-health billing information is collected in the same manner as a regular office visit. Medicare covers tele-medicine as well as most insurance companies, but it will be ultimately my financial responsibility to check with my insurance plan to determine coverage.

I understand and agree that a medical evaluation via tele-health may limit my healthcare provider's ability to fully diagnose a condition or disease which may further warrant an in-person evaluation. As the patient, I agree to accept responsibility for following my healthcare providers recommendation, including further diagnostic testing, such as lab testing, imaging studies, or endoscopies.

To the extent permitted by law, I agree to waive and release my healthcare provider and his practice from any claim I may have about the tele-health visit.

I certify that I have read and understand this agreement prior to my signature, with the opportunity to have questions answered to my satisfaction.

Name (Print): ____

Signature:____

Date: ____

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PATIENT CONSENT TO RECEIVE OUT-OF-NETWORK SERVICES WITH ESTIMATED COST OF CARE TO PERFORM SERVICES

(A.B. 72 Services)

The facility in which you will be recelvmg non-emergent care is an in-network facility, meaning the facility may or may not have a contract with your health plan or insurer. However, as part of your care at this facility, a physician who is out-of-network with your health plan or insurer will be participating in your treatment. When a patient receives non-emergent services at a contracting facility from a non-contracted provider, California law (Health & Safety Code §1371.9 and Insurance Code §10112.8) permits patients with coverage for out-of-network benefits to receive non-emergent care from a non- contracted provider at a contracting facility if the patient is notified and consents to the out-of-network services at least 24 hours in advance of the care.

To be completed by the person obtaining consent on behalf of the non-participating physician:

Name of Non-Contracted Provider:	**CAREY B. STROM, M.D.**
Name of Contracted Facility:	**Surgery Center of Beverly Hills** **Cedars Sinai Medical Center**
Service/Procedure to be provided by CAREY B. STROM, M.D.	**Scheduled Time and Date of Procedure**
	Time: **Date:**

My signature below and initials on each line means that I have read and understand the following:

1. The healthcare provider named above will be involved in my episode of care and is not contracted with my plan or insurer.________**(Initials)**
2. I understand that I may elect to seek the same service from a contracted provider for lower out-of-pocket costs by contacting my plan or insurer to arrange for the services.______________**(Initials)**
3. I was provided with the above estimate of the out-of-pocket cost of care at least 24 hours in advance of the scheduled care.________**(Initials)**
4. I understand that any costs incurred as a result of my use of this non-contracted provider shall be in addition to any in-network cost sharing amounts. Additionally, the costs may not count toward my annual out-of-pocket maximum on in-network benefits or any deductible for in-network benefits._______ **(Initials)**
5. If the estimate changes, the non-contracting provider will obtain a separate written consent from me ormy Authorized Representative, unless circumstances arise during delivery of services that are unforeseeable at this time and will change the estimate.___________**(Initials)**

To be completed by the member or the member's authorized representative:

Signature of patient, parent (if patient under age 18) or authorized representative:		
Printed name of patient, parent (if patient under age 18) or authorized representative:		
Date:	Time:	AM PM