PERRY T. MANSFIELD, M.D. Inc.
San Deigo Regional Head and Neck Center Inc.

Perry T. Mansfield, MD
Brianna Harris, MD
Kimberly Cockerham, MD
Seerat Poonia, MD
Annette Kiviat, PA-C

REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms.	Marital status (Check one) ❑ Single / ❑ Mar / ❑ Div / ❑ Sep / ❑ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ website ❑ Internet Search

E-mail: Cell Phone:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary Insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Perry Mansfield M.D. Inc or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

PATIENT HEALTH SURVEY (Page 1 of 2)

Patient Name: (LAST, FIRST, MIDDLE) _____ Date: _____

Please indicate in your own words the reason for your visit today:

Explain:

Check **YES** if you are experiencing any of the symptoms or conditions below:

GENERAL	Y?	**RESPIRATORY**	Y?	**ENDOCRINE**	Y?
Fevers		Cough		Thyroid Problems	
Chills		Dyspnea (difficulty breathing)		**ALLERGIC / IMMUNOLOGIC**	
Sweats		Excessive Sputum		Hay Fever	
Loss of Appetite		Hemoptysis (coughing blood)		Allergies	
Fatigue		Wheezing		HIV Positive	
Weight Change		**CARDIO**		**MUSCOLOSKELETAL**	
EYES		Chest Pain		Back Pain or Neck Pain	
Blurring		Difficulty Breathing During Exercise		Joint Pain	
Diplopia (double Vision)		Heart Condition		Joint Swelling	
Irritation		Palpitations		TMJ	
Discharge		Syncope (loss of consciousness)		**SKIN**	
Vision Loss		Peripheral Edema (swelling)		Rash	
Increased Sensitivity to Light		**GASTROINTESTINAL**		Itching	
EARS/NOSE/THROAT		Nausea		Suspicious Lesion/Mole	
Earache		Vomiting		**NEUROLOGIC**	
Ear Discharge		Heartburn		Weakness	
Tinnitus (ringing in ears)		Diarrhea		Syncope (fainting)	
Decrease in Hearing		Acid Reflux		Tremors	
Sinus Trouble		Abdominal Pain		Vertigo (dizziness)	
Nasal Congestion		**GENITOURINARY**		**PSYCHIATRIC**	
Nose Bleeds		Incontinence		Depression	
Snoring		Dysuria (pain during urination)		Anxiety	
Facial Pain / Pressure		Urinary frequency / Urgency		Memory Loss	
Sore Throat		**HEMATOLOGIC/LYMPHATIC**		Mental Disturbance	
Hoarseness		Abnormal Bruising			
Dysphagia (trouble swallowing)		Bleeding			
		Enlarged Glands			

DRUG ALLERGIES (note reactions/side-effect)	**ENVIROMENTAL ALLERGIES**
☐ No Known Drug Allergies	☐ No Known Allergies

MEDICATIONS (with dose and frequency)

PHARMACY NAME, NUMBER, LOCATION

PATIENT HEALTH SURVEY (Page 2 of 2)

PAST MEDICAL HISTORY: Have you had or do you have any of the following								
Transfusion	☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Fibromyalgia	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO	Abnormal bleeding	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Migraines / Headaches	☐ YES	☐ NO	Anemia	☐ YES	☐ NO
COPD/Emphysema	☐ YES	☐ NO	Kidney Infection	☐ YES	☐ NO	Hepatitis	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO	Kidney Stones	☐ YES	☐ NO	Ulcer, gastritis, reflux	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Bladder Infection	☐ YES	☐ NO	Weight Loss	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO	Fits/ Convulsions	☐ YES	☐ NO
Atrial Fibrillation	☐ YES	☐ NO	Prolonged Antibiotics	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Hypertension	☐ YES	☐ NO	Sinusitis	☐ YES	☐ NO	Tumor*	☐ YES	☐ NO
Hypercholesterolemia	☐ YES	☐ NO	Thyroid Disorder	☐ YES	☐ NO	Cancer*	☐ YES	☐ NO
Injury to ear, nose, throat	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO	HIV	☐ YES	☐ NO
Specify site and treatment for cancer, tumor or growth:								

HISTORY OF OPERATIONS:

1.	Year:
2.	Year:
3.	Year:
4.	Year:
5.	Year:
6.	Year:

FAMILY HISTORY (note relationship)

Heart Attack	☐ Y	☐ N		Hypertension	☐ Y	☐ N	
Cancer (w/type)	☐ Y	☐ N		Allergies	☐ Y	☐ N	
Stroke	☐ Y	☐ N		Diabetes	☐ Y	☐ N	
Asthma	☐ Y	☐ N		Hearing Loss	☐ Y	☐ N	
Immunodeficiency	☐ Y	☐ N		Sinus Disease	☐ Y	☐ N	
Bleeding Disorder	☐ Y	☐ N		Other	☐ Y	☐ N	

SOCIAL HISTORY: Have you ever smoked or chewed tobacco? ☐ **YES** ☐ **NO** How Long?

If you currently smoke…… How Long? How much Packs per day.

If you quit….. Year you quit:

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO** How often?

Do you or have you ever used drugs? ☐ **YES** ☐ **NO** Please list:

SOURCE OF INFORMATION IF OTHER THAN PATIENT:

DATE:

SIGNATURE OF PERSON OR PATIENT ACQUIRING INFORMATION:

DATE:

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SENTA CLINIC

PERRY T. MANSFIELD M.D. INC

Patient Name: (LAST, FIRST, MIDDLE) _____Date:_____

Height _____ Weight _____
Age _____ Male / Female _____

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes ☐	No ☐
Do you often feel **T**IRED, fatigued, or sleepy during daytime?	Yes ☐	No ☐
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes ☐	No ☐
Do you have or are you being treated for high blood **P**RESSURE?	Yes ☐	No ☐

BANG		
BMI more than 35kg/m2?	Yes ☐	No ☐
AGE over 50 years old?	Yes ☐	No ☐
NECK circumference > 16 inches (40cm)?	Yes ☐	No ☐
GENDER: Male?	Yes ☐	No ☐

TOTAL SCORE	0	

High risk of OSA: **Yes 5 – 8**

Intermediate risk of OSA: **Yes 3 – 4**

Low risk of OSA: **Yes 0 - 2**

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AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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.*

AUTHORIZATION:
I hereby authorize: _____
Physician/ Healthcare Facility

To release information on _____ (patient's name) _____ (DOB) 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 provider that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _Perry Mansfield M.D. Inc./ San Diego Regional Head and Neck Inc.
Name
_3590 Camino Del Rio North Suite 100_____
Address
_San Diego_____ ___CA_____ ___92108_____
City State Zip code

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

This authorization is:
[X] Unlimited (all records, excluding Substance Abuse, Mental Illness, HIV Diagnosis/ Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/ Substance Abuse _____(initial) HIV Diagnosis/ Treatment_____(initial)
Psychiatric/ Mental Health _____(initial) Genetic Information _____(initial)
Test for Antibodies to HIV _____(initial)

DURATION: This authorization shall be effective immediately and remain in effect until canceled in writting

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 of 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.

_____ _____
Signature of patient *or legal/ personal Representative patient* Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) Date

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BROKEN APPOINTMENTS POLICY

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us in advance if you are unable to do so. We currently have a waiting list for appointments and when you give us advance notice of appointment changes, this helps us accommodate other patients. We appreciate your consideration.

Please read and sign our policy as indicated below:

BROKEN APPOINTMENTS POLICY:

PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS WITHOUT PRIOR NOTIFATION TO OUR OFFICE MAY BE CHARGED A FEE OF $50.

- This "broken appointment" fee is NOT RECOVERABLE from your insurance plans and will be charged to the patient.
- Repeated "broken appointments" may negatively impact your healthcare and result in notification to your referring physician of disengagement from our practice. Please be kind enough to call in advance, preferably 24 hours in advance if you need to cancel or reschedule an appointment.

Thank you for your assistance and courtesy towards other patients:

_____
Patient Name (Print)

I have read and agree to the "Broken Appointment" Policy.

_____ _____
Patient or Legal Guardian Signature Date

NEUROSURGERY
Sanjay Ghosh, MD
Scott P. Leary, MD
Alois Zauner, MD
Amanda W Gumbert, PA-C
Felix Regala, PA-C
Cassie Petit, PA-C
Deb Frantz, PA-C

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Jeannine Shively, PA-C

OPTHALMOLOGY/
NEURO-ORBIT-PLASTICS
Kimberley Cockerham, MD
Cindy Ocran, MD

NEUROLOGY
Ian M. Purcell, MD, PhD
Monali Patel, MD

LOCATIONS

MESA COLLEGE
7625 Mesa College Drive
Suite 305A
San Diego, CA 92111

**CORPORATE &
MAILING ADDRESS**

**MISSION VALLEY
3590 Camino Del Rio N
Suite 100
San Diego, CA 92108**

**PH: 619-810-1111
FX: 619-229-4938**

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Financial Policy

We cannot guarantee your benefits or eligibility with your insurance plan. Your insurance plan is a contract between you and your insurance company.

Upon completion of our patient Registration Form and your Assignment of Benefits, we will extend the benefit offered by your insurance company and file for reimbursement. We will handle the necessary insurance filing paper work for you. All payments are expected at the time of visits for services not covered by your insurance plan.

If your insurance company pays only a portion of the bill or denies the claim, an explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of the financial obligation. We will notify you if this occurs and we will request payment in full.

I have read the above and I understand and agree to the San Diego Regional Head and Neck Center Inc./ Perry T. Mansfield, M.D., Inc. Financial Policy. I authorize the release of any medical information necessary to process insurance claims and to comply with medical reviews and audits. I further authorize payment of my benefits be made to Perry T. Mansfield, M.D., Inc. for services provided to me. I understand that the ultimate responsibility for payment of services remains mine.

_____ _____
Print Name of Patient or Responsible Party Date

_____
Signature of Patient or Responsible Party

*A Copy of this signature is valid as the original

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Senta CT scanner/ ChEARS Audiology/ Amerisleep Diagnostics/ E-Prescribe

In the circumstance that a San Diego Regional Head and Neck Center/Perry T. Mansfield, M.D. Inc. physician determines that you require further radiology or audiology evaluation or are in need of a Sleep Study and recommends that you have this preformed at Senta Imaging, LLC or ChEARS Audiology or Amerisleep Diagnostics, please be aware that they may have financial interest in the aforementioned entities.There are other facilities available in our community where the same procedure(s) can be performed, and you do have the option to use one of these alternates. You will not be treated any differently regardless of the entity you choose to be treated. If you have any questions regarding this, please feel free to contract our office at (619) 810-1111. We do electronic prescribing and require your written consent for viewing your Rx history.

Patient Name (Please print)

_____

I have read and agree to the above and understand that Perry T. Mansfield, M.D. Inc. has a financial interest in the aforementioned entities.

_____ _____

Patient Signature/ *Legal Guardian* Date

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Acknowledgment of Receipt of Notice of Privacy Practices San Diego Regional Head and Neck Center Inc. and Perry T. Mansfield, M.D. Inc.

I hereby acknowledge that I received a copy of this Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in the reception area.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

E-mail address: _____

Signature: _____ **Date:** _____

Patients Name: _____

Date of Birth: _____ **Phone Number:** _____

If not signed by patient, please indicate:

Relationship:

☐ Parent of Guardian of minor patient.

☐ Guardian or Conservator of an incompetent patient.

☐ Beneficiary or personal representative of deceased patient

Patient Name: _____ **Date:** _____

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SENTA CLINIC

INFORMED CONSENT FOR TELEHEALTH SERVICES

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Responsibility for the patient care should remain with the patient's local clinician, as does the patient's medical record.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her local healthcare site (i.e. home) while the physician consults and obtains test results at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a specialist.
- Minimizing patients and healthcare specialists' exposure to rapidly disseminating, contagious diseases such as the COVID-19 (i.e., coronavirus disease) pandemic, especially in the setting of the current social interaction nationwide restrictions.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the consultant may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

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INFORMED CONSENT FOR TELEHEALTH SERVICES (cont.)

By checking the box associated with "Informed Consent", you acknowledge that you understand and agree with the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
4. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
6. I understand that telemedicine does not replace an in-person medical or allied health practitioner's face-to-face evaluation in cases of urgent or emergent medical conditions, and does not exclude the necessity of a direct physician's consultation and/or office visit, urgent care or emergency room evaluations.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction.

I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

By signing this form, I hereby state that I have read, understood, and agree to the terms of this document.

Patient Name: _____ Date: _____

Signature: _____

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Photography/Electronic Medical Record Consent

Purpose: I consent to the taking of photographs, slides, recording of films and/or creation of multi-media items of parts of my ENT body part I am being treated for, such as nasal cavity or face, in connection with the ENT surgery procedure(s) to be performed by Perry T. Mansfield, M.D. Inc. physicians. I authorize the use and disclosure of the photographs and images of me for the following purposes:

✓ Uploaded to my electronic medical records

✓ Submitted to my insurance company for authorization requests; via online insurance portals, fax or email insurance provides for submission.

✓ Emailing of your photos obtained to your personal email, if requested , Please PRINT the email address they maybe sent to: _____

Confidentiality please note: Your photos **will not be shared** with anyone other than your insurance company for request of authorizations . They will remain a permanente part of your electronic medical record.

Notice: San Diego Regional Head and Neck Center Inc. and Perry T. Mansfield, M.D. Inc., as well as many other organizations and individuals such as doctors, nurses, dentists, hospitals and health plans are required by law to keep your health information confidential. I understand that if I have authorized the emailing of my photo's it may breach the HIPAA confidentiality act, as email is not a known secure method.

Your Rights: I understand that I have the right to have the nasal endoscopy, filming or photography stop at any time. Giving permission for us to use these items is voluntary, however please note: some insurance companies require us to submit proof of abnormalities for authorization consideration. I may refuse to give permission without any penalty or loss of care or services. My treatment, payment, enrollment and eligibility for benefits do not depend on my signing this permission form. If I have any questions about my rights, I may contact Eric Espia at 3590 Camino del Rio North, Suite 103 San Diego, CA 92108 or via phone at: 619- 810-1111

Expiration: Unless I revoke my permission earlier, this authorization expires on_____. If no date is indicated, this authorization will expire fifty years after the date of my signing this form.

Patient Initials: _____

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Seerat Poonia, MD
Annette Kiviat, PA-C

I give permission for these multimedia items to be taken or made and used: Photographs, audiotapes/audioclips, radiographs and other medical images, other multimedia items, and any other health information regarding my medical condition or surgical intervention required to improve my health.

Revoking your permission: I understand that I may change my mind and withdraw my permission for use of the photographs, films or other materials at any time, without any penalty or loss of care or services. To revoke my permission, I must write a letter, sign it and deliver it to SENTA Clinic 3590 Camino del Rio North, Suite 100 San Diego, CA 92108. The revocation letter will take effect when SENTA Clinic receives it, except to the extent that Perry T. Mansfield, M.D. Inc., or others have already relied on it. If the multimedia items have been shared with your insurance or emailed to you at your request, it may not be possible to recall them.

I agree that San Diego Regional Head and Neck Center Inc. and Perry T. Mansfield M.D. Inc. will own any and all rights in the multimedia items listed above. I waive any and all right that I may have in the use of my likeness, photograph, appearance in these multimedia items.

I have read this consent about the use of multimedia items that contain my health information. I understand the permissions I am giving. My questions have been answered to my satisfaction and I agree to what this form says.

_____	_____
Signature of Patient or Legal Representative	Date
_____	_____
Printed name of Legal Representative (if applicable)	Relationship to Patient
_____	_____
Signature of Witness or Interpreter	Date
_____	_____
Signature of Person Obtaining Consent	Date

NEUROSURGERY
Sanjay Ghosh, MD
Scott P. Leary, MD
Alois Zauner, MD
Amanda W Gumbert, PA-C
Felix Regala, PA-C
Cassie Petit, PA-C
Deb Frantz, PA-C

OTOLARYNGOLOGY/
HEAD & NECK SURGERY
Perry T. Mansfield, MD
Michael J. O'Leary, MD
Brian H. Weeks, MD
Brianna Harris, MD
Seerat Poonia, MD

R. Stuart Weeks, MD
Emeritus
Annette Kiviat, PA-C
Jeannine Shively, PA-C

OPTHALMOLOGY/
NEURO-ORBIT-PLASTICS
Kimberley Cockerham, MD
Cindy Ocran, MD

NEUROLOGY
Ian M. Purcell, MD, PhD
Monali Patel, MD

LOCATIONS

MESA COLLEGE
7625 Mesa College Drive
Suite 305A
San Diego, CA 92111

**CORPORATE &
MAILING ADDRESS**

**MISSION VALLEY
3590 Camino Del Rio N
Suite 100
San Diego, CA 92108**

**PH: 619-810-1111
FX: 619-229-4938**

PERRY T. MANSFIELD, M.D. Inc.
San Deigo Regional Head and Neck Center Inc.

Perry T. Mansfield, MD
Brianna Harris, MD
Kimberly Cockerham, MD
Seerat Poonia, MD
Annette Kiviat, PA-C

SENTA CLINIC
NOTICE OF NON-DISCRIMINATION

Discrimination is Against the Law

San Diego Regional Head and Neck Center Inc./ Perry T. Mansfield M.D. Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Senta Clinic does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

San Diego Regional Head and Neck Center Inc./Perry T. Mansfield M.D. Inc.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages.

If you need these services, contact Perry T. Mansfield, M.D. Inc.'s Clinic's Civil Rights Coordinator: **Eric Espia**. If you believe that Perry T. Mansfield, M.D. Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Eric Espia, 3590 Camino Del Rio North, Suite 100, San Diego, CA 92108, Phone: 619.810.1111, Fax: 619.229.4938, eespia@sentaclinic.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Eric Espia** is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

https:/ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

PERRY T. MANSFIELD, M.D. Inc.
San Deigo Regional Head and Neck Center Inc.
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GRIEVANCE POLICY AND PROCEDURES

POLICY:

It is the policy of San Diego Regional Head and Neck Center Inc./Perry T. Mansfield, M.D. Inc. not to discriminate on the basis of race, color, national origin, sex, age or disability. Perry T. Mansfield, M.D. Inc. has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Eric Espia, 3590 Camino Del Rio North, Suite 100, San Diego, CA 92108, Phone: 619.810.1111, Fax: 619.229.4938, Eespia@sentaclinic.com. who has been designated to coordinate the efforts of San Diego Regional Head and Neck Center Inc./Perry T. Mansfield, M.D. Inc., to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for SENTA Clinic to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

PROCEDURES:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of SENTA Clinic relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Board of Directors within 15 days of receiving the Section 1557 Coordinator's decision. The Board of Directors/etc. shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Perry T. Mansfield, M.D. Inc./San Diego Regional Head and Neck Center Inc. will make appropriate arrangements to ensure that individuals with disabilities and with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

Dated: July 28, 2021

PERRY T. MANSFIELD, M.D. Inc.
San Deigo Regional Head and Neck Center Inc.
Perry T. Mansfield, MD
Brianna Harris, MD
Kimberly Cockerham, MD
Seerat Poonia, MD
Annette Kiviat, PA-C

Non-Discrimination Policies and Procedures Acknowledgement Form

I, _____ have received the followingdocuments from the San Diego Regional Head and Neck Center Inc./ Perry T. Mansfield, M.D. Inc. clinic's Civil Rights Coordinator/Doctors office:

- NON-DISCRIMINATION POLICY
- POLICY AND PROCEDURES FOR COMMUNICATION WITH PERSONS WITH LIMITED ENGLISH PROFICIENCY
- POLICY AND PROCEDURE FOR AUXILIARY AIDS AND SERVICES FOR PERSONS WITH DISABILITIES
- GRIEVANCE POLICY AND PROCEDURES
- NOTICE OF PROGRAM ACCESSIBILITY
- NON-DISCRIMINATION STATEMENT
- LANGUAGE ASSISTANCE NOTICE

I have reviewed and understand these materials. I acknowledge I have received the Policies and Procedures laid out. I understand that if I have questions about any of San Diego Regional Head and Neck Center/Perry T. Mansfield, M.D. Inc's Policies and Procedures, I may contact Eric Espia at 619-810-1111.

_____ _____
Signature of Patient Date

_____
Signature of Clinic Staff/Witness

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.