

## **WELCOME TO THE HEART TO HEART MEDICAL CENTER**

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_



Thank you for scheduling an appointment with Dr. Shiroko Sokitch. Her services include general medicine, acupuncture and Chinese medicine.

**Due to the extreme environmental sensitivity of some of our patients, we ask that you don't wear any perfume, cologne, or anything else with strong scents.**

Because we make every effort to keep on schedule, we have enclosed the forms you will need for your first visit. Please fill them out and bring them with you to avoid scheduling delays.

**New Patient will need to notify us forty-eight hours in advance of their scheduled appointment; to cancel or change a Tuesday appointment, please let us know by the previous Friday. If you need to cancel or reschedule a follow-up appointment, please be sure to give us at least twenty-four hours notice. You will be charge half of the office visit.**

Our office is located at 3471 Regional Parkway Suite D, just past the FedEx building. From Santa Rosa, take either Fulton Road or the Airport Blvd exit. Go WEST on Airport Blvd, toward the airport. Pass the Airport Theater, and cross the railroad tracks. TURN LEFT onto Regional Parkway, and continue for .3 miles to 3471, which is on the right side.

If you have any questions or need more information, please don't hesitate to give us a call at (707) 524-9640.

Thank you for your time. We look forward to working with you.

**Heart to Heart Medical Center**  
**Shiroko Sokitch, MD**



3471 Regional Parkway Suite D  
Santa Rosa, CA 95403-8209  
707 524-9640  
www.thmc.com

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Email address: \_\_\_\_\_ Who referred you? \_\_\_\_\_

**WE DO NOT BILL MOST INSURANCE COMPANIES** — fill in below *ONLY* if we have agreed to bill your insurance for you.

**\*\*Please let us copy your insurance card\*\***

Ins. Co. Name: \_\_\_\_\_ Ins. Co. Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy/Claim #: \_\_\_\_\_ Policy holder: \_\_\_\_\_

Insured's SS#: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Attorney's name (if any): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary or referring physician: \_\_\_\_\_ Phone: \_\_\_\_\_

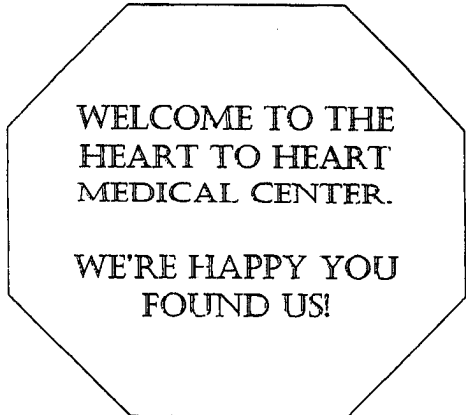
Date of injury: \_\_\_\_\_

Who should be notified in case of an emergency?

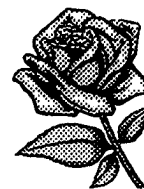
Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_







## Treatment & Payment Agreement

**Insurance:** The Heart to Heart Medical Center does not bill insurance companies for your office visits with only very few exceptions. We accept checks, credit cards, ATM cards and cash at time of service. We will provide you with information necessary to apply for reimbursement from your own insurance company.

**Appointments:** Cancellations without sufficient notice will be subject to a charge of up to 50% of the treatment fee. New Patients have 48 hours for cancellation and are subject to a 50% charge for late cancellation.

**Payment Policy:** All charges are the responsibility of the patient or the patient's guardian. I understand that charges for services are due at the time of service unless there is a prior agreement to bill my insurance company on my behalf. A credit card will be kept on file for the patient as a guarantee of payment and will be used for all PAST DUE PAYMENT BALANCES OVER 90 DAYS. It is the patients responsibility to provide up dated credit card information.

**Emergency Services:** A variety of health services are provided on an outpatient basis, but we do not admit patients to hospitals, or make hospital rounds.

**Cancer:** Dr. Sokitch is not an oncologist (cancer specialist) and does not treat cancer.

**Primary Physical:** Dr. Sokitch is NOT a Primary Physician and does not have Hospital privileges.



### Payment Agreement

I hereby authorize the processing of my medical insurance either by electronic or manual methods by the Heart to Heart Medical Center and/or its practitioners. My signature below authorizes payment to Dr. Sokitch for all medical benefits to which I am entitled.

I further authorize Dr. Sokitch to release all medical and/or insurance claims information necessary to secure payment. I recognize my financial obligation of any co-insurance, deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as the original.  
A credit card will be kept on file for the patient as a guarantee of payment for services render.

I further understand that Dr. Shiroko Sokitch has Opted-out of Medicare and will no longer bill Medicare. It is now the patient's responsibility to make payment at the time of services.

**By signing below, I acknowledge that I have read the above Treatment and Payment Agreement, and understand my responsibilities to both.**

Print name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Signature: \_\_\_\_\_

## TO OUR PATIENTS: NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and how you can get access to your health information. This is required by the Privacy Regulations stated in the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

### Use and disclosure of health information:

1. To public health authorities that are authorized by law to collect information.
2. Lawsuits and other proceedings in response to a court or administrative order.
3. Required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or others.
5. If you are a member of US foreign military forces, vets as well, and if required by appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. For Workers Compensation and similar programs.

### Your rights regarding health information:

1. Communications: You can request that Shiroko Sokitch, MD communicate with you about your health in a particular manner or at a certain location. You may want us to contact you at home only.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. You have the right to request that we restrict our disclosure to only certain individuals, such as family members. We are not required to agree; however if we do, we are bound by our own agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information such as medical records and billings records, but not psychotherapy notes. You must submit your request in writing, or complete request forms available in this office.
4. You may amend your health information if you believe it is incorrect or incomplete. To request copies or an amendment to your health information, please complete the required form in our office or request in writing and send to: Shiroko Sokitch, MD, 3471 Regional Parkway, Santa Rosa, CA 95403, attn: medical records.
5. Right to copy of this notice: You are entitled to receive a copy of Notice of Privacy Practices. You may ask us for a copy of this notice at any time. Contact our front office or call us at (707) 524-9640.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice in writing or with the Secretary of the Dept. of Health and Human Services.
7. Our practice will obtain your written authorization for uses/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 our office manager, privacy officer for our office at (707) 524-9640.

**I hereby acknowledge that I have read and reviewed this Privacy Notice.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_