Malini Soogoor MD
1687 Erringer Road #211
Simi Valley, CA 93065
P: 805-520-1101 | F: 805-426-8046

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	M.I	BIRTHDATE (MM/DD/YYYY)	SEX:

ADDRESS:	APT:

CITY:	STATE:	ZIP CODE:

HOME PHONE:	CELL PHONE:	WORK PHONE:

EMAIL:	PREFERRED METHOD OF COMMUNICATION [ ] EMAIL [ ] HOME PHONE [ ] CELL PHONE [ ] WORK PHONE

EMERGENCY CONTACT INFORMATION

LAST NAME:	FIRST NAME:	RELATIONSHIP TO PATIENT:

HOME PHONE:	CELL PHONE:	WORK PHONE:

PHARMACY INFORMATION

PHARMACY NAME:	PHONE #

ADDRESS:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	INSURANCE TYPE: [ ] HMO [ ] PPO [ ] POS [ ] OTHER

MEMBER ID #	GROUP #

POLICY HOLDER NAME:	RELATIONSHIP TO PATIENT [ ] SELF [ ] SPOUSE [ ] PARENT [ ] OTHER

SECONDARY INSURANCE	SECONDARY INSURANCE MEMBER ID #	SECONDARY INSURANCE GROUP #

Patient Name_____ **DOB**_____

Patient/Guardian Signature_____ **Date**_____

Malini Soogoor MD
1687 Erringer Road #211
Simi Valley, CA 93065
P: 805-520-1101 | F: 805-426-8046

PHYSICIAN INFORMATION	
PRIMARY CARE PHYSICIAN	PHONE NUMBER:
REFERRING PHYSICIAN	PHONE NUMBER
OTHER PHYSICIANS IN YOUR HEALTH CARE	
PHYSICIAN NAME:	PHONE NUMBER:
PHYSICIAN NAME	PHONE NUMBER:
PHYSICIAN NAME	PHONE NUMBER:

MEDICAL HISTORY
REASON FOR YOUR VISIT TODAY:
PLEASE LIST ALL PAST AND CURRENT MEDICAL PROBLEMS WITH APPROXIMATE DATE OF ONSET
PLEASE LIST ALL PAST SURGICAL PROCEDURES AND APPROXIMATE DATE OF PROCEDURE

Patient Name_____ **DOB**_____

Patient/Guardian Signature_____ **Date**_____

Malini Soogoor MD
1687 Erringer Road #211
Simi Valley, CA 93065
P: 805-520-1101 | F: 805-426-8046

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS? [ ] YES [ ] NO	IF YES, LIST WHICH ONES	TYPE OF REACTION

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING DOSAGE AND FREQUENCY)

MEDICATION NAME	DOSAGE	FREQUENCY

SOCIAL HISTORY

DO YOU SMOKE: (CHECK ONE) [ ] YES [ ] NO [ ] QUIT	IF YES, HOW MANY PACKS A DAY?		
	IF QUIT, HOW MANY YEARS DID YOU SMOKE?	HOW MANY PACKS DID YOU USED TO SMOKE?	WHAT YEAR DID YOU QUIT?

DO YOU DRINK ALCOHOL? (CHECK ONE) [ ] YES [ ] NO [ ] QUIT	IF YES, HOW OFTEN?
	IF QUIT, HOW OFTEN AND WHAT YEAR DID YOU QUIT?

DO YOU USE RECREATIONAL DRUGS? (CHECK ONE) [ ] YES [ ] NO [ ] QUIT	IF YES, HOW OFTEN AND WHAT TYPE?
	IF QUIT, HOW OFTEN, WHAT TYPE, AND WHAT YEAR DID YOU QUIT?

Patient Name_____ **DOB**_____

Patient/Guardian Signature_____ **Date**_____

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

POLICIES AND NOTICES

Please review this packet carefully and sign the Master Acknowledgement form located at the end.

1 FINANCIAL RESPONSIBILITY AGREEMENT

I acknowledge that I am financially responsible for all charges associated with my medical care at California Infectious Disease Consultants including:

(1) Co-pays, deductibles, and co-insurance as determined by my insurance plan.
(2) Charges for services not covered by my insurance plan.

I understand the following:

(1) It is my responsibility to confirm the terms of my insurance coverage and to ensure that services provided are covered by my plan.
(2) Payment is due at the time of service unless other arrangements have been made in advance.

I further agree that I will be responsible for any outstanding balances if my insurance provider denies coverage or fails to make payment.

2. PATIENT'S EXTENDED SIGNATURE AUTHORIZATION AND CONSENT FORM

In accordance with regulations, we are required to maintain documentation confirming that we have provided you with privacy and other relevant information for review, should you wish to do so. Additionally, we must retain records of certain authorizations. In compliance with regulations effective April 1, 1982, physicians may request a signature authorization from the patient to submit assigned or unassigned insurance claims to the patient's insurance company on their behalf. This signature will be retained in our files for future claims. By signing below, you acknowledge and agree to the following:

"I request that payment of authorized medical insurance benefits be made on my behalf to Malini Soogoor M.D. Inc. for any services provided by the physician(s). I authorize the release of my medical information necessary for the processing of claims related to these services."

3. NOTICE OF PHYSICIAN LICENSING

This notice informs you that Dr. Malini Soogoor is a licensed medical professional regulated by the Medical Board of California.
Medical Board of California
Phone: (800) 633-2322
Website: www.mbc.ca.gov

4. NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. **Purpose of Consent**: I consent to the use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations as outlined in our Notice of Privacy Practices.
2. **Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before deciding whether to sign this consent form. The Notice explains how we use and disclose your PHI for treatment, payment, and healthcare operations, and outlines your rights regarding your PHI. You can request a copy of our Notice before you sign this consent. We encourage you to read it thoroughly.
3. **Right to Amend**: We reserve the right to change our privacy practices as described in the Notice. If

changes occur, a revised Notice of Privacy Practices will be provided to you, and the changes may apply to all of your PHI we maintain.

4. **Right to Revoke**: You have the right to revoke this consent at any time by providing written notice to Malini Soogoor, M.D., Inc. Please understand that revocation will not affect any actions we took in reliance on this consent prior to its revocation. Additionally, we may decline to treat or continue treating you if you revoke this consent.

5. PHYSICIAN-PATIENT ARBITRATION AGREEMENT

This agreement is entered into by the undersigned patient ("Patient") and the undersigned physician, including their medical group, partners, employees, agents, and affiliated entities ("Physician"), and is intended to govern the resolution of disputes arising from medical services rendered.

Article 1: Agreement to Arbitrate
In accordance with California law, the Patient and the Physician mutually agree that any dispute related to medical malpractice—including, but not limited to, whether any medical services rendered were unnecessary, unauthorized, improperly performed, negligently rendered, or otherwise defective—shall be resolved exclusively through binding arbitration. This agreement expressly waives the right to a trial by jury or court process, except as permitted under California law for judicial review of arbitration proceedings. Both parties acknowledge and voluntarily agree to this waiver of constitutional rights and acceptance of arbitration as the method of dispute resolution.

Article 2: Scope of Arbitration
This agreement is binding upon the Patient, the Patient's heirs, spouse, representatives, and any children—whether born or unborn—at the time of the occurrence giving rise to the claim. In the case of a pregnant Patient, the term "Patient" includes both the mother and the expected child or children. The following claims must be resolved through arbitration: (1) All claims for monetary damages exceeding the jurisdictional limit of small claims court, including claims for loss of consortium, wrongful death, emotional distress, or punitive damages. (2) Claims against the Physician, their partners, associates, corporation, medical group, employees, agents, and affiliates arising out of or related to medical care provided. (3) The filing of a lawsuit by the Physician for the collection of fees does not waive the right to compel arbitration of any malpractice claim.

Article 3: Arbitration Procedures and Applicable Law
(1) Selection of Arbitrators: (a) A demand for arbitration must be communicated in writing. (b) Each party will select an arbitrator (party arbitrator) within 30 days of the demand. A neutral arbitrator will then be selected by the party arbitrators within 30 days of a written request for the neutral arbitrator. (c) Arbitration will proceed under the rules of a neutral arbitration provider, such as the American Arbitration Association (AAA) or Judicial Arbitration and Mediation Services (JAMS). (2) Arbitration Costs (a) The expenses of the neutral arbitrator shall be shared equally unless the neutral arbitrator determines otherwise. Each party is responsible for their own legal fees, expert fees, and other personal costs. (2) Confidentiality (a) All aspects of the arbitration process, including evidence, testimony, and the final award, shall remain confidential and not disclosed to third parties, except as required by law. (4) Discovery (a) Discovery shall be conducted under California Code of Civil Procedure Section 1283.05, with depositions permitted without prior approval. (5) Governing Law: (a) This agreement is governed by California law, including but not limited to California Code of Civil Procedure Sections 340.5, 667.7, and Civil Code Sections 3333.1 and 3333.2 (6) Class Action Waiver (a) All claims must be brought on an individual basis. Class action lawsuits or representative actions are expressly waived.

Article 4: General Provisions
(1) All claims based on the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. (2) Claims shall be deemed waived and forever barred if: (a) They would be time-barred under applicable California statutes of limitations (b) the claimant fails to diligently pursue arbitration in accordance with the procedures outlined herein. (3) If any provision of this agreement is found to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

Article 5: Revocation and Opt-Out
The Patient may revoke this agreement by delivering written notice to the Physician within 30 days of signing. If not revoked within this period, the agreement shall remain binding for all medical services rendered, regardless of when the services are provided.

Article 6: Retroactive Effect
This agreement applies to all medical services rendered by the Physician, including services provided prior to the date of signing, effective as of the first date of treatment.

Article 7: Independent Providers and Facilities
This agreement applies to the Physician and their employees, agents, affiliates, and associated facilities but does not extend to independent contractors or providers not directly employed by or affiliated with the Physician, unless expressly agreed otherwise.

6. PATIENT-PHYSICIAN CONTRACT

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

I understand that I am voluntarily entering into a contractual relationship with the Physician for the provision of medical care. I acknowledge that medical treatment is based on professional judgment and that no specific outcome or guarantee has been promised. I further understand that frivolous claims of medical malpractice negatively impact medical providers and may lead to increased costs, limited access to care, and harm to a provider's reputation. As a condition of receiving medical care, I agree that I will not initiate or participate in any meritless or frivolous claim of medical malpractice against the Physician. If I initiate a meritorious medical malpractice claim, I agree that any expert witness I retain must be board-certified by the American Board of Medical Specialties in the same specialty as the Physician, be in good standing with their respective board, and adhere to the ethical guidelines and code of conduct of their certifying board. Any expert witness must also consent to formal peer review of their testimony by their specialty board or society. I further agree that any attorney I retain, as well as any expert witness acting on my behalf, will be required to adhere to these provisions. Physician agrees to be held to the same expert witness standards in the event of a dispute. Both parties agree that a determination by a recognized specialty board or society following due process may be used as supporting or refuting evidence in assessing the validity of a claim. This Agreement is binding upon the Patient/Guardian and Physician, as well as their heirs, successors, representatives, and assigns. It applies to any claim for medical malpractice, whether based on contract, negligence, battery, or any other legal theory. Any dispute arising under this Agreement shall be resolved exclusively in the state or federal courts of California and shall be governed by the laws of the State of California. I agree to indemnify, defend, and hold Physician harmless from any damages, legal fees, or costs resulting from a frivolous or meritless lawsuit initiated by me or on my behalf. Both Physician and Patient/Guardian voluntarily waive any right to a jury trial for any dispute related to this Agreement. I understand that any settlement discussions, mediation proceedings, or arbitration involving claims against the Physician must remain confidential unless disclosure is required by law. I further agree not to make false, misleading, or defamatory statements about the Physician in any public or private forum, including social media. I acknowledge that monetary damages may not provide adequate relief for a breach of this Agreement, and I agree that in the event of a breach, the Physician may seek injunctive relief, specific performance, or other equitable remedies. If any part of this Agreement is found to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

7. ACKNOWLEDGMENT OF RISK AND WAIVER OF LIABILITY FOR EXPOSURE TO INFECTIOUS DISEASES

Acknowledgment of Risk
I understand and acknowledge the following:

1. **Inherent Risk of Exposure:**
    - The Practice specializes in the diagnosis, treatment, and management of infectious diseases, which inherently increases the risk of exposure to pathogens, including but not limited to:
        - Viruses (e.g., COVID-19, influenza, HIV, hepatitis)
        - Bacteria (e.g., tuberculosis, MRSA)
        - Fungi or other infectious agents.
2. **No Guarantee of Protection:**
    - While the Practice follows stringent infection control protocols, including regular sanitization, use of personal protective equipment (PPE), and patient screening, no environment can guarantee complete protection from exposure to infectious diseases.
3. **Personal Responsibility:**
    - I agree to comply with all infection prevention measures required by the Practice, including wearing masks, practicing hand hygiene, and following social distancing protocols when applicable.
    - I will inform the Practice if I am experiencing symptoms of an infectious disease (e.g., fever, cough, shortness of breath) or have had recent exposure to someone with an infectious disease prior to my visit

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

MASTER ACKNOWLEDGMENT

By signing below, I confirm the following:

1. I have received, read, and understood all of the policies and notices contained in this new patient packet for **Malini Soogoor MD**
2. I acknowledge and agree to the following:

    (1) **Financial Responsibility Agreement**
    (2) **Patient's extended signature authorization** (insurance/claims)
    (3) **Notice of physician licensing**
    (4) **Notice of privacy practices (HIPAA)**
    (5) **Physician–patient arbitration agreement**
    (6) **Patient–physician contract**
    (7) **Infectious disease waiver**

3. I understand that these documents are legally binding and will remain in effect unless revoked in writing where applicable.
4. I have been informed of my right to request copies of any of these policies or authorizations.
5. My signature below applies to all policies listed above.

Patient/Legal Representative Name (Print): _____

Date of Birth: _____ **Relationship if not patient:** _____

Signature: _____**Date:** _____

FOR OFFICE USE

Physician Representative: _____

Physician Stamp: _____

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This Authorization allows the healthcare provider(s) named below to release confidential medical information and records.I, the undersigned, hereby authorize the following healthcare provider(s) or healthcare facility to release my medical information and records as described below: (Please specify the name(s) and contact information of the provider(s) or facility(ies) from which records will be obtained.)

Provider/Facility Name(s): _____

To release information regarding my medical history, diagnosis, treatment, prescriptions, illness or injury, prognosis, consultation, x-rays, laboratory results, correspondence, and/or other relevant medical records to provide continuity of care and treatment, to facilitate coordination of services, and for legal or insurance purposes. This may include disclosure via mail, fax, or secure electronic methods (e.g., email, patient portal).

Recipient:

Malni Soogoor, MD
1687 Erringer Rd, Ste 211
Simi Valley, CA 93065
Phone (805)-520-1191 | Fax: 805-426-8046

Scope of Authorization

This Authorization is:

❒ **Unlimited** (all records, except for those related to Substance Abuse, Mental Health, and HIV Diagnosis/Treatment)

❒ **Limited to the following medical information/records**: _____

Special Authorization for Sensitive Information

I specifically consent to the release of the following protected health information:

1. _____(initial) **Drug/Alcohol/Substance Abuse**
2. _____(initial) **Psychiatric/Mental Health Records**
3. _____(initial) **HIV Diagnosis and Treatment**
4. _____(initial) **Test for Antibodies to HIVDuration of Authorization:** This Authorization shall be effective immediately and remain in effect until: ❒ **Indefinitely** ❒ **Until**_____

Disclosure Beyond Authorization

I understand that this Authorization does not permit any further use or disclosure of my medical information except as permitted by law.

Validity of Authorization

A photocopy or facsimile of this Authorization shall be as effective as the original.

Patient Rights

I have been informed of my right to request a copy of this Authorization after signing, and I acknowledge that I have received, reviewed, and fully understand the contents of this form.

Important Notes for HIPAA Compliance and Legal Protection:

1. **Patient Consent:** By signing this form, you consent to the use and disclosure of your health information as stated above. Your health information will only be shared with the parties specified in this Authorization and for the purposes outlined.
2. **Sensitive Information:** Special protections apply to sensitive health information, including but not limited to substance abuse, mental health, and HIV-related information. Your initialing next to any of these categories confirms your consent for their release.
3. **Revocation Rights:** You retain the right to revoke this Authorization at any time, subject to the limitations outlined in the form. Revocation must be submitted in writing, and will not affect disclosures made prior to the revocation.
4. **State and Federal Compliance:** This Authorization is designed to comply with all relevant provisions of the **Health Insurance Portability and Accountability Act (HIPAA)** and **California state law** regarding the privacy and security of health information.

PATIENT SSN (OPTIONAL)	PATIENT DATE OF BIRTH (MM/DD/YYYY)
SIGNATURE OF PATIENT OR LEGAL/PERSONAL REPRESENTATIVE	RELATIONSHIP IF OTHER THAN PATIENT
PRINT FULL LEGAL NAME	DATE (MM/DD/YYYY)
WITNESS NAME	WITNESS SIGNATURE

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

CONSENT FOR TEXT AND EMAIL COMMUNICATION

Malini Soogoor MD (the Practice)

This consent form outlines the terms and risks associated with text messaging and email communication between the Practice and its patients. By signing, you consent to the use of these communication methods and acknowledge their associated risks and responsibilities, in compliance with state and federal laws, including HIPAA.

The Practice uses text and email communication sparingly, only for essential purposes such as appointment reminders, administrative updates, and prescription refill confirmations. Sensitive health information (e.g., test results, diagnoses) will not be shared via these methods unless explicitly authorized through a separate signed agreement. Patients may not initiate communication via text or email; the Practice will use these methods only when necessary and expects patients to follow up via phone or in-person visits.

While the Practice implements reasonable measures to protect your privacy, text and email communications may not fully comply with HIPAA security standards. These methods lack encryption, increasing the risk of unauthorized access, interception, or misdirection due to technical issues, outdated contact information, or user error. By signing, you accept these risks and agree to notify the Practice of any changes to your contact information or if your device is compromised.

Text and email are not intended for emergencies or urgent medical needs. In such cases, call 911 or visit the nearest emergency room. Responses to non-urgent messages may take up to two business days.

Participation is optional, and you may withdraw consent at any time by providing written notice to the Practice. Once consent is withdrawn, all communication will occur via phone or in-person visits.

By signing below, you acknowledge that you understand the risks and limitations of text and email communication and voluntarily consent to their use. You release the Practice, its providers, and staff from liability for any unintended disclosures or security breaches associated with these methods.

Preferred Communication Methods (Check all that apply):

☐ Text Messaging
☐ Email
☐ I don't wish to be contacted via email or text message.

PREFERRED NUMBER FOR TEXT COMMUNICATION	PREFERRED EMAIL FOR EMAIL COMMUNICATION
PRINT FULL LEGAL NAME	DATE (MM/DD/YYYY)
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	RELATIONSHIP IF OTHER THAN PATIENT

Malini Soogoor MD
1687 Erringer Road, Suite #211 • Simi Valley, CA 93065
Tel: (805) 520-1191 Fax: (805) 426-8046

TELEHEALTH/TELEMEDICINE CONSENT FORM

By signing this form, I understand and agree to the following:

Purpose of Telehealth/Telemedicine Services:

Telehealth/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, nurse practitioners, registered nurses, medical assistants, and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service. I agree to share my personal information with, but not limited to, family members, caregivers, legal representatives, or guardians. The information may be used for diagnosis, therapy, follow-up, and/or education.

Information Shared During Telehealth/Telemedicine Services:

Telehealth/Telemedicine requires the transmission, via Internet or telecommunication devices, of health information, which may include, but is not limited to: (1) Progress reports, assessments, or other intervention-related documents (2) Biophysiological data transmitted electronically. (3) Videos, pictures, text messages, audio, and other digital forms of data.

Privacy and Confidentiality:

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine sessions that identifies me will not be given to anyone without my consent, except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to use telehealth/telemedicine services, I am consenting to California Infectious Disease Consultants (CIDC) sharing my protected health information with certain third parties as more fully described in the CIDC Privacy Policy. I understand, agree, and expressly consent to CIDC obtaining, using, storing, and disseminating to necessary third parties information about me, including my image, as necessary to provide telehealth/telemedicine services. As with any Internet-based communication, I understand that there is a risk of security breaches. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption.

Additional Participants and Technical Support:

Individuals other than my clinical care team or consulting providers may also be present and have access to my information during the telehealth/telemedicine session. These individuals may operate or repair the video or audio equipment used. Such persons will adhere to applicable privacy and security policies.

Limitations of Telehealth/Telemedicine:

Telehealth/Telemedicine sessions may not always be possible. Disruptions in signals or problems with Internet infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, or audio interference) that prevent effective interaction between consulting clinicians, participants, patients, or the care team. I hereby release and hold harmless California Infectious Disease Consultants and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

Health Information During Telehealth/Telemedicine:

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during the course of my evaluation and treatment. These professionals may not have access to my full medical record or information held at California Infectious Disease Consultants. I understand that I will be given information about test(s), treatment(s), and procedure(s), as applicable, including the benefits, risks, possible problems or complications, and alternative choices for my medical care through the telehealth/telemedicine visit.

Right to Withdraw Consent:

I have the right to withhold or withdraw my consent for telehealth/telemedicine services at any time and revert to traditional in-person clinic services. I understand that if I withdraw my consent, it will not affect any future services or benefits to which I am entitled.

Consent Acknowledgment:

I hereby consent to the use of telehealth/telemedicine in the provision of care and agree to the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements, and I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

PRINT FULL LEGAL NAME	DATE AND TIME
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE	RELATIONSHIP IF OTHER THAN PATIEN