DR. USHA MANTHA M.D

BOARD CERTIFIED FAMILY PHYSICAN

1902 ROYALTY DR #200

POMONA CA 91767

NOTICE TO ALL PATIENTS

DEAR PATIENTS:

EFFECTIVE JULY 1ST 2025 WE WILL START COLLECTING A $25 NO SHOW/ SAME DAY CANCELLATION FEE FROM PATIENTS WHO NO SHOW OR RESCHDULE SAME DAY FOR APPOINTMENTS. THE OFFICE REQUIRES A 48 HOUR NOTICE FOR RESCHDULES AND CANCELLATIONS.

PATIENT SIGNATURE:

CARD INFORMATION

CARD NUMBER:

EXP:

CVV:

ZIP CODE:

Usha Mantha MD Inc , 1902 Royalty Drive , Suite 200, Pomona , CA 91767,
Usha Mantha MD Inc , 1101 N . Euclid Avenue , Suite B, Upland , CA 91786

MANDATORY NOTIFICATION FROM MEDICAL BOARD OF CALIFORNIA TO ALL PATIENTS REGARDING OPEN PAYMENTS DATABASE
1/1/2023

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

ACKNOWLEDGED, SIGNED AND DATED

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PATIENT NAME DATE

Usha Mantha MD Inc.

Dear patients

It is required that patients are seen every 3 to 4 months (as planned) for refill of their medications. A pharmacy's request for refill will be declined if not seen within in previous 3 to 4 months.
Medications will be refilled only after the visit in the office.

Thanks
Dr.Mantha and staff

Patient Name_____

Patient signature _____

Date_____

Usha Mantha, M.D.

1902 ROYALTY DRIVE, SUITE #200
POMONA, CA. 91766
PHONE # (909) 629-2290

1101 N. EUCLID AVE. SUITE B
UPLAND CA. 91786
PHONE # (909) 920-5804

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please REQUEST Medical Information FROM:

NAME OF HEALTH CARE PROVIDER, MEDICAL OFFICE OR HOSPITAL

STREET ADDRESS

CITY, STATE AND ZIP CODE

PHONE NUMBER

FAX NUMBER

Please SEND Medical Information TO:

NAME OF PERSON, HEALTH CARE PROVIDER OR MEDICALOFFICE

STREET ADDRESS

CITY, STATE AND ZIP CODE

PHONE NUMBER

FAX NUMBER

I hereby authorize _____ to release the medical information
(name of health care provider, medical office or hospital)
as indicated above.

Name of patient _____ Date of Birth _____

Address _____ City State Zip Code Phone Number _____

SPECIFY RECORDS TO BE RELEASED:

☐ General Medicine Information (from_____ to _____)
☐ X-RAY reports ☐ Laboratory Results ☐ List of Medication
☐ Other (Specify) _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE _____ RELATIONSHIP (IF PATIENT DID NOT SIGNED) _____

DATE _____

THIS AUTHORIZATION EXPIRES IN 12 MONTHS FROM DATE SIGNED UNLESS NOTED OTHERWISE

IT IS THE POLICY OF THIS MEDICAL PRACTICE THAT WE WILL ADOPT, MAINTAIN, AND COMPLY WITH OUR NOTICE OF PRIVACY PRACTICES, WHICH SHALL BE CONSISTENT WITH HIPAA AND CALIFORNIA LAW

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)
DIRECTIVA DE ATENCIÓN MEDÍCA ANTICIPADA
(Código Antenticado Sección 4701 de California)

Dear Patient:

As your physician, we are required to ask any patient over the age of 18 if they have an existing Advance Health Care Directive so that we can incorporate the information into your medical record. You are not required to give us this information, but we are required to ask. Please complete this form and return it to the receptionist.

Thank You.

Estimado(a) Paciente:

Como su médico, es necesario que yo le pregunte a cualquier paciente mayor de 18 años de edad si tiene una Directiva de Atención Médica Anticipada para que podamos incorporar la información a nuestro expediente médico. No es necesario que Ud. nos proporcione esta información, pero es necesario que yo se lo pregunte. Por favor llene este formulario y regréselo a la recepcionista.

Gracias

PATIENT NAME:_____ SS #: ____ ____ ____ ____ (last 4 digits)

*NOMBRE DE(L)(LA) PACIENTE:*_____ *# SS:* ____ ____ ____ ____ (los últimos cuatro digitos)

PATIENT SIGNATURE:_____ DATE: _____

FIRMA DE(L)(LA) PACIENTE: _____ *FECHA:*_____

- **I decline to answer these questions** ☐ Yes ☐ No
- *Me rehúso a contestar estas preguntas* ☐ *Sí* ☐ *No*
- **Do you have an Advance Health Directive?** ☐ Yes ☐ No
- *¿Tiene una Directiva Médica Anticipada?* ☐ *Sí* ☐ *No*

If yes, please indicate which type of Directive:
De ser así, indique que tipo de Directiva:

☐ **Durable Power of Attorney for Healthcare**
☐ *Poder Notarial Duradero para Atención Médica*

☐ **California Natural Death Act**
☐ *Decreto de Muerte Natural de California*

☐ **Living Health Care Will**
☐ *Testamento (para que no se le prolongue la vida en caso de peligro de muerte) de Atención Médica*

☐ **Other:**_____

☐ *Otro:*_____

- **Will you bring us a copy of your Directive?** ☐ Yes ☐ No
- *¿Nos traerá Ud. una copia de su Directiva?* ☐ *Sí* ☐ *No*

INTERNAL OFFICE USE ONLY

TYPE OF HEALTH CARE DIRECTIVE RECEIVED:	DATE RECEIVED
Durable Power of Attorney for Health Care	
California Natural Death Act	
Living Health Care Will	
Other:	

PARA USO INTERNO SOLAMENTE

TIPO DE DIRECTIVA DE ATENCIÓN MÉDICA RECIBIDA:	*FECHA RECIBIDA*
Poder Notarial Duradero para Atención Médica	
Decreto de Muerte Natural de California	
Testamente (para que no se le prolongue la vida en caso de peligro de muerte) de Atención Médica)	
Otro:	

MEMBER ELIGIBILITY WAIVER

Dear HMO, PPO, EPO, or POS Patient: Date:

Verification of your coverage for health plan benefits cannot be made at this time. Services will be provided to you at this visit; however, in the event your coverage is not effective, you will be held responsible for payment.

Patient Name _____ SS # (last 4 digits) ____ ____ ____ ____

Subscriber's Name _____ SS # (last 4 digits) ____ ____ ____ ____

Address _____ City _____ St _____ Zip _____

Subscriber's Phone (Day) _____ (Evening) _____

Medicare No. _____ Date of Birth _____

Physician _____

Subscriber's Employer _____ Phone No. _____

Patient's Signature _____

EXENCÍON DE ELEGIBLIDAD DE MIEMBRO

Estimado(a) Paciente de HMO, PPO, EPO, o POS: Fecha:

Por el momento no se puede verificar su cobertura para beneficios del plan médico. Sin embargo, en esta visita se le proporcionarán a Ud. los servicios, y en caso de que su cobertura no esté vigente, Ud. será responsable del pago.

Nombre de(l)(la) Paciente _____ # SS (los últimos cuatro dígitos) ____ ____ ____ ____

Nombre del Subscriptor: _____ # SS (los últimos cuatro dígitos) ____ ____ ____ ____

Dirección _____ Ciudad _____ Edo. _____ C.P. _____

Tel. del Subscriptor (Día) _____ (Noche) _____

No. de Medicare _____ Fecha de Nac. _____

Médico _____

Empleador del Subscriptor _____ No. Tel. _____

Firma de(l)(la) Paciente _____

USHA MANTHA MD,INC
1101 N. EUCLID AVE. SUITE B
UPLAND, CA.91786
(909)920-5804

PATIENT ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of the NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that the Privacy Policy can be revised or amended at any time and that I may receive a revised copy upon written request.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Patient Signature_____ Date:_____

(Or) Authorized Representative:_____ (i.e. parent)

DESIGNATED FAMILY MEMBER AUTHORIZATION FORM

Protected Health Information will only be released from this office with a properly executed authorization from patient or his/her personal representative, except for treatment, payment, or health care operations, and as otherwise required by law.

However, in the event that a family member is required to discuss my medical condition, I assign the following person to be the primary source of communication regarding my medical condition. Additionally, I understand that this authorization will remain in effect until in writing by me.

Name of Authorized Person	Date of Birth	Relationship

Signature of Patient _____ Date _____

Answer Phone Authorization Form

I give the above entity my permission to leave non-emergency message or normal results on my answer phone. I understand that this authorization will remain in effect until revoked by me

Signature of Patient_____ Date_____

GENERAL CONSENT

I hereby consent and request diagnostic procedures including X-rays, blood tests, medical treatment, including immunizations and treatment deemed advisable by the professional staff of USHA MANTHA, M.D.
I acknowledge that I have this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

Witness

Patient's Signature

Date

Parent's or Legal Guardian's Signature

CONSENTIMIENTO GENERAL

Por este medio solicito y doy autorizacíon para procedimientos de diagnóstico incluyendo radiografias, análisis de sangre inclusive vacunas y tratamiento médico que el personal de USHA MANTHA, M.D. consideren aconsejables. Reconozco que tuve la oportunidad de leer este formulario y entiendo su contenido. Se me dio la oportunidad de hablar sobre esto se me contestaron a mi entera satisfacción todas las preguntas que hice.

Testigo

Firma del paciente

Fecha

Firma del padre, tutor o paciente

USHA MANTHA, M.D.

DATE *(FECHA)* _____

ACCT. # _____

☐ NEW
☐ UPDATE

PLEASE PRINT CLEARLY
FAVOR DE IMPRIMIR

ALL SHADED AREAS MUST BE COMPLETED
DEBEN COMPLETARSE TODAS LAS AREAS SOMBREADAS

PATIENT *(PACIENTE)*

PATIENT LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	PREVIOUS NAME (MAIDEN) *(APELLIDO DE SOLTERA)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CODIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMIENTO)*	
SEX *(SEXO)* ☐ M ☐ F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SS # (LAST 4 DIGITS) *# SS (LOS ULTIMOS CUATRO DIGITOS)* ____	
MARITAL STATUS *(ESTADO CIVIL)* ☐ S ☐ M ☐ W ☐ D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZOA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CODIGO POSTAL)*	

RESPONSIBLE PARTY (MAIN INS. CARDHOLDER) *(NOMBRE DE LA PERSONA ASEGURADA)*

PATIENT LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CODIGO POSTAL)*	
HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )	MESSAGE TELEPHONE *(TELEFONO PARA DEJAR RECADO)* ( )	BIRTHPLACE *(LUGAR DE NACIMIENTO)*	
SEX *(SEXO)* ☐ M ☐ F / BIRTH DATE *(FECHA DE NAC.)*	DRIVER'S LICENSE NUMBER *(No. DE LICENCIA PARA MANEJAR)*	SS # (LAST 4 DIGITS) *# SS (LOS ULTIMOS CUATRO DIGITOS)* ____	
MARITAL STATUS *(ESTADO CIVIL)* ☐ S ☐ M ☐ W ☐ D	OCCUPATION *(OCUPACION)*	DATE EMPLOYMENT BEGAN *(FECHA EN QUE EMPEZOA TRABAJAR)*	
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*		EMPLOYER TELEPHONE *(TELEFONO DEL TRABAJO)* ( )	
STREET ADDRESS *(DOMICILIO DEL TRABAJO)*	CITY *(CIUDAD)* STATE *(ESTADO)*	ZIP *(CODIGO POSTAL)*	

EMERGENCY CONTACT

RELATIVE / FRIEND (Not living at same address)
(REFERENCIA PERSONAL (Que no viva en su mismo domicilio))

LAST NAME *(APELLIDO)*	FIRST NAME *(NOMBRE DE PILA)*	INITIAL *(INICIAL)*	RELATIONSHIP *(PARENTESCO)*
STREET ADDRESS *(DOMICILIO)*	CITY *(CIUDAD)* STATE *(ESTADO)* ZIP *(CODIGO POSTAL)*		HOME TELEPHONE *(TELEFONO DE LA CASA)* ( )
EMPLOYER NAME *(NOMBRE DEL EMPLEADOR)*	ADDRESS *(DOMICILIO)*		EMPLOYER TELEPHONE *(TELEFONO DEL EMPLEADOR)*

PLEASE COMPLETE INFORMATION ON REVERSE SIDE

Important Notice to All our Valued Patients/2025

Effective January 2025 , we are implementing a strict policy to ensure highest level of car and safety for all our patients.

Please take notice of it as follows:

1- Any patients taking 1 or more prescribed medications will be required to be seen every 3 months, RESULTING in minimum 4 visits in one year.

2- Patients taking controlled prescription medications have to be seen every 2 months, RESULTING in 6 visits in one year.

3- All patients are expected to have an annual physical exam once a year with appropriate Lab work .

4- No prescriptions can be called in for a sick visit unless seen in office within past 3 months.

We request your understanding and co operation in this matter. Your health and well being is our top most priority and following these policy guidelines will enable us to continue to provide the best possible care.

Thank you !
Dr. Usha Mantha MD & Staff

PATIENT ACKNOWLEDGEMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **NOTICE OF PRIVACY PRACTICES** prior to signing this consent. I understand that this organization has the right to change its **NOTICE OF PRIVACY PRACTICES** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **NOTICE OF PRIVACY PRACTICES.**

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

I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient Name: _____

Signature: _____ _____

Authorized Representative: _____

Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

WHO WILL FOLLOW THIS NOTICE:

This notice describes the privacy practices of:

USHA MANTHA, M.D.

All these entities, sites and locations will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment and/or its own limited and Medical Office operation purposes described in this notice.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **TREATMENT** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

- CALL OR WRITE YOUR PHYSICIANS OFFICE
  ATTN: PRIVACY OFFICER

web | www.drumanthamd.com
email | drmantha@yahoo.com

USHA MANTHA MD., MRCOG FAAFP
Board Certified Family Physician

Dear Patients,

My staff and I would like to welcome you to my office. I'm honored to be your physician, and committed to providing you with the best care I can. We will strive to make your experience at our office a pleasant one. Here are some of the unique features of our practice. First visit will be a "Get Acquainted Visit" with the doctor or for an "Acute illness". Routine Physicals and Well Woman Exam appointments will subsequently be scheduled. Medical records release form should be signed at your initial visit.

We call you with test results and reports that we ordered in our office within two weeks. If you have not heard from our office within two weeks, please call our office to request your results.

It's your responsibility and our duty to keep your name, mailing address, phone number, and insurance information updated. So please help our office by ***notifying us of any changes at each visit.*** *Referrals to other Physician's, Labs, and EKG's can take between 24-48 hours. Please notify us ahead of time.*

It will give me great pleasure to work with you on these goals, either through my own expertise, through reading I might give you, or by referral to other health professionals as appropriate. I look forward to working with you and your family as your doctor. Please contact me whenever you like to talk about anything you think may be affecting your health. It's my hope that we can have a relationship where the lines of communication are open and communication goes both ways. I will listen to you at least as much as I talk. Let's work together to help you live the satisfying life that you deserve.

Sincerely,

Usha Mantha, M.D. and Staff

Pomona | 1902 Royalty Drive • Suite 200 • Pomona, CA 91767 • Tel: (909) 629-2290 Fax: (909) 629-7278
Upland | 1101 N. Euclid Avenue • Suite B • Upland, CA 91786 • Tel: (909) 920-5804 Fax: (909) 920-5825