PATIENT INFORMATION

Last Name:	MI:	Sex:
First Name:	DOB:	SSN:
Preferred Name:	Marital Status:	

CONTACT INFORMATION

Mobile Phone:	Physical Address:
Home Phone:	City: State: Zip:
Email:	Mailing Address:
Preferred Contact Method:	City: State: Zip:
Emergency Contact Name:	Relation to Patient:
Phone Number:	

YOUR CARE TEAM

Primary Care Physician:	Imaging Facility Name:
Phone Number:	Location:
	Phone Number:
Preferred Laboratory Name:	Pharmacy Name:
Location:	Location:
Phone Number:	Phone Number:

INSURANCE INFORMATION

Insurance:	Group #:
Member ID #:	Policy Holder DOB:
Policy Holder Name:	Relationship to Patient:

LEGAL GUARDIAN/GUARANTOR INFORMATION (if applicable)

Last Name:	MI:
First Name:	DOB:
Sex at birth:	Marital Status:
Home Phone Number:	SSN:
Mobile Phone Number:	Mailing Address:
Physical Address:	City: State: Zip:
City: State: Zip:	Relationship to Patient:

Patient Health Information

Primary Care Physician: _____ Referring Provider: _____

Appointment Reason: _____

MEDICATIONS:

(list all prescribed or over the counter medications, supplements, or vitamins taken regularly or semi-regularly)

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:

(list all drug, food, metal (jewelry and environmental)

_____

_____

MEDICAL HISTORY:

(circle all current and past medical problems)

Anemia	Cancer	Heart disease	Liver disease
Anxiety Disorder	Coronary Artery Disease	Hepatitis	Pulmonary Embolism
Arthritis	Deep Vein Thrombosis	High Cholesterol	Reflux/GERD
Asthma	Depression	Hypertension	Seizures/Epilepsy
Autoimmune disease	Diabetes	Hyperthyroidism	Stroke
Bleeding disorder	Diverticulitis	Hypothyroidism	Tuberculosis
Bronchitis	Gout	Kidney disease	Breast cancer
COPD	Headaches	Kidney stones	Rectal Bleeding

Other: _____

MEDICAL HISTORY

(circle one)

Blood clots/Excessing-bleeding: Yes / No

Adverse reaction to Anesthesia : Yes / No

Sleep Apnea: Yes / No

Do you use a CPAP: Yes / No

REVIEW OF SYSTEMS

Are you currently or have had problems with:		*Please describe all yes answers.*
Skin	Yes / No	_____
Ears, Nose,Throat	Yes / No	_____
Cardiac/High blood pressure	Yes / No	_____
Lungs (asthma, infection)	Yes / No	_____
Stomach/Digestion	Yes / No	_____
Hematologic/Bleeding problems	Yes / No	_____
Diabetes	Yes / No	_____
Cancer	Yes / No	_____
Musculoskeletal	Yes / No	_____
Neurological	Yes / No	_____
Psychiatric Problems	Yes / No	_____
Reproductive/Sexual Problems	Yes / No	_____
Fever/Chills	Yes / No	_____
Night sweat	Yes / No	_____
Night pain	Yes / No	_____
Unexpected weight loss	Yes / No	_____

Location of pain _____

What makes it worse _____

What makes it better _____

Any prior non-operative treatment for this pain (PT, Injections, Etc.) _____

If so, when _____

Have you had a previous surgery on this body part before _____

If yes, type of surgery _____

When _____

Surgeon and Facility _____

PAIN **WHAT HAVE YOUR TRIED**

None		Physical Therapy		Chiropractic	
Mild-Occasional		Medications		Acupuncture	
Mild (Stairs only)		Exercise		Surgery	
Mild (Walking and Stairs		Brace		Other	
Moderate- Occasional					
Moderate-Continual					
Severe					

SURGICAL HISTORY

(Please list all surgeries and the date of service)

_____

_____

_____

_____

_____

FAMILY HISTORY

(List history of the following conditions. Include relationship i.e. maternal grandmother, paternal grandmother)

Cancer: _____

Diabetes: _____

Heart Disease/Problems: _____

Bleeding Problems: _____

Respiratory Problems: _____

Problems with Anesthesia: _____

Osteoporosis: _____

Stroke: _____

Blood Clots/Excessive Bleeding: _____

Autoimmune Disease: _____

Other Problems: _____

SOCIAL HISTORY

Occupation: _____ Any heavy lifting: _____ Marital Status: _____

Previous or Current Smoker? _____ How much in a day? _____ Years of use?_____

Do you drink caffeine? _____ How much? _____ How often? _____

Do you drink Alcohol? _____ How much? _____ How often? _____

History or current Illicit Drug use? _____ Chewing Tobacco? _____

Do you have an Advanced Directive? _____

HIPPA - YOUR RIGHTS TO PRIVACY

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Sierra Medical Partnership
Sierra Management Group. Privacy Officer

A required by the health information portability and Accountability Act of 1996 (HIPPA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes of the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Patient Last Name: _____

Patient First Name: _____

This health information may be disclosed to:
*If no approved recipients, please indicate so with "N/A"

Last Name:	First Name:	Relationship to Patient:

Please mark the type of records that may be disclosed if/when the above approved person(s) contact us for information:

_____ Any and all health information other than psychotherapy notes may be released. including, but not limited to. mental health records protected by the Lanteman-Peths-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below.

_____ All psychotherapy notes may be released, except as specifically provided below:

_____ Claims/Billing Records

_____ Other: _____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the Individual"):
_____

- I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.
- I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.
- I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

- I understand that if I do <u>not</u> sign this form:
  - A health plan may not enroll me or make me eligible for benefits.
  - My physician will not perform the expert employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

The authorization is in effect and will remain in effect until: _____(One year after date of signature) I understand that I have a right to received a copy of this authorization upon request.

Signature: _____ Date: _____

Legal Guardian/Guarantor: _____

If not signed by the patient, please indicate the relationship: _____

THE SIERRA MEDICAL PARTNERSHIP

<u>PATIENT FINANCIAL PARTNERSHIP POLICY</u>

To Our Patients:

We are pleased that you have chosen The Sierra Medical Partnership to provide your medical services. We are committed to providing you with the best possible medical care to meet your needs. Our practice firmly believes we must maintain a high level of understanding and excellent communication with our patients throughout their care. We pride ourselves on communicating with you any anticipated out-of-pocket costs to create a better understanding and level of expectation. Our Patient Financial Partnership Policy is designed to be completely transparent to avoid any surprises during your medical care.

The following information is provided to clarify our policies about the financial portion of your medical care:

1. **Time of Collection:** We collect co-payments, outstanding balance payments, and costs of service (self-pay), when you check in for your appointment with our front desk staff. You must present a current insurance card at each visit.

   - If you do not present a current insurance card or we are unable to confirm your insurance eligibility you may be responsible for payment at the time of your visit. You will receive reimbursement from our office if your insurance pays the claim at a later date. Your co-payment may be adjusted after the time of service depending upon the final payment decision from your health insurance plan
   - Patients being seen without insurance coverage are required to pay the cost of service upon arrival.

2. **Financial Policy:** Patients are responsible for: payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by your insurance plan. If payment from your insurance company is not received within 60 days from date of service, you may be expected to pay the balance in full. The only exception to this is an approved workers compensation claim. If your workers compensation status is reversed, you will be expected to pay the balance in full.

   - Our office requires a credit card on file for all patients with high deductible HMO insurance and PPO insurance without secondary insurance, to enable us to collect co-insurance and deductibles. By signing this document, you are authorizing your credit card to be charged up to $150.00 per visit. Your credit card will only be charged after review of the final explanation of benefits from each applicable insurance company for services provided. Prior to your card being charged, you will receive an email regarding your remaining balance and the date in which the transaction will take place.
   - Our office accepts many forms of payment: cash, personal checks, MasterCard, Visa, Discover, and American Express. We do not accept ATM only cards (cards without a Visa or MasterCard logo). All personal checks must be addressed to "The Sierra Medical Partnership" and will be electronically debited from your account the day of service. Returned checks will be subject to a collection fee of $25.

3. **Account Balances:** Financial estimates are not always exact. Account balances reflect the final service(s) rendered and insurance benefits allowed under your chosen plan. For patients experiencing financial hardships, cases will be reviewed on an individual basis and may be subject to application of our Payment Plan Policy. Past due accounts will affect your ability to have appointments scheduled.

4. **Missed Appointment Policy:** If you must cancel an appointment, our office requires a minimum of 24-hours notice. All appointments missed without notice are subject to a $50.00 no-show fee. All procedures or surgeries missed without noticed are subject to a $250.00 no-show fee. All in-office procedures missed without notice are subject to a $100.00 no-show fee. Missed appointments, procedures, and surgeries, represent a cost to us, to you, and other patients who could have been seen in the time set aside for.

5. **Disability Insurance Processing:** If your physician has instructed you that time will need to be taken off work for recovery, and you are applying for California State Disability Insurance, there will be a $15 charge for each form required to be completed by our office.

If you decide you can't or won't meet these guidelines, we may need to reschedule any future appointments or services until a time when you are able to do so. Any account balance that remains after efforts to collect payment by our Billing department could be transferred to a 3rd party collection partner. Please note a situation of this type would be considered on a case-by-case basis.

It is extremely important that we be notified of any changes in your insurance status or your insurance carrier. This includes: eligibility changes, becoming newly insured or uninsured, acquiring additional or new secondary coverage. ***It is also important*** that we have your correct address information on file. Please notify us if there is a change to your address, telephone, or other contact information. If you do not update us with your information, we will not be able to bill your insurance. This could result in a direct balance billing to you.

We understand that there are many reasons why you may be seeking out care from our facility, whether it be planned or unexpected. We hope to help you as much as possible through this process and be an advocate for you as you navigate through the financial portion of your medical care.

By signing below, you certify that you have received, read, and understand our Patient Financial Partnership Policy (Version 1.0).

Printed Name of Patient	Date
Signature of Patient or Legal Guardian	Date