Primaria Medical Clinic

222 W.6th St. Corona, CA. 92882
Tel: (951)278-2530 Fax: (951)278-9746

WELCOME

PATIENT INFORMATION:

Today's Date:_____

Name:_____
Address:_____
City:_____State____Zip_____
Driver's License#:_____Exp.Date_____
Marital Status: S M W D
Employer:_____
Address:_____
City:_____State____Zip_____

Date of Birth:_____
Home Phone:( )_____
Cell Phone:( )_____
Work Phone:( )_____
Department or extension:_____
SSN:_____
Spouse's Name:_____
Parents's Name:_____

LOCAL EMERGENCY CONTACTS:

Name:_____
Relationship:_____
Phone Number:( )_____
Address:_____

Name:_____
Relationship:_____
Phone Number:( )_____
Address:_____

PRIMARY MEDICAL INSURANCE:

Insurance Company:_____
Policy ID#:_____

SECONDARY MEDICAL INSURANCE:

Insurance Company:_____
Policy ID#:_____

MEDICAL PROBLEMS:

1._____
2._____
3._____
4._____
5._____
6._____

DRUG ALLERGIES:_____

MEDICATIONS: (Please list directions)

1._____
2._____
3._____
4._____
5._____

6._____
7._____
8._____
9._____
10._____

RISK FACTORS: Cigarettes: Yes/No___per day/week Alcohol: Yes/No ___per day/week

How did you hear about our office?

_____Relative or Friend _____Insurance Plan_____Advertisement

_____ _____ _____
Patient Signature Date Physician Signature

THANK YOU

COMMUNICATION CONSENT AGREEMENT

I UNDERSTAND THAT UNDER FEDERAL LAW (HIPAA), THIS MEDICAL OFFICE MAY **NOT** RELEASE ANY MEDICAL INFORMATION TO ANY INDIVIDUAL, WITHOUT MY EXPRESS WRITTEN PERMISSION. LAW ENFORCEMENT AND COURT ORDER ARE THE TWO EXCEPTIONS TO THIS REQUIREMENT. I, THEREFORE **GIVE** PERMISSION OT THIS OFFICE TO RELEASE MEDDICAL INFORMATION ON MY BEHALF, TO THE FOLLOWING PERSONS (S)

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

PHONE #: _____ AGE: _____ DOB: _____

DRIVERS LICENSE #: _____ SSN: _____

OTHER FORMS OF ID: _____

PATIENT SIGNATURE: _____ DATE: _____

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature _____ Date _____ Physician Signature _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & 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:

- Conduce, 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 for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above 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.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice Of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason

Primaria Medical Clinic

PRIVACY PRACTICES ACKNOWLEDGEMENT NOTICE

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.

UNDERSTANDING YOUR HEALTH RECORDS/INFORMATION

EACH TIME YOU VISIT A HOSPITAL, PHYSICIAN AND OTHER HEALTHCARE PROVIDERS, A RECORD OY YOUR VISIT IS MADE. TYPICALLY, THIS RECORD CONTAINS YOUR SYMPTOMS, EXAMINATION, TEST RESULTS, DIAGNOSES, TREATMENT AND PLAN FOR FUTURE CARE OR TREATMENT. THIS INFORMATION OFTEN REFERRED TO AS YOUR HEALTH OR MEDICAL RECORD, SERVES AS:

- BASIS OF PLANNING YOUR CARE AND TREATMENT
- MEANS OF COMMUNICATION AMONG THE MANY HEALTH CARE PROFESSIONALS WHO CONTRIBUTE TO YOUR CARE
- LEGAL DOCUMENT DESCRIBING THE CARE YOU RECEIVED
- MEANS BY WHICH YOU OR A THIRD PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED
- A TOOL IN EDUCATING HEALTH PROFESSIONALS
- A SOURCE OF DATA FOR FACILITY PLANNING AND MARKETING
- A TOOL WHICH WE CAN ASSESS AND CONTINUALLY WORK TO IMPROVE THE CARE WE RENDER AND THE OUTCOMES WE ACHIEVE.
- UNDERSTANDING WHAT IS IN YOUR RECORD AND HOW YOUR HEALTH INFORMATION IS USED HELPS YOU TO ENSURE ITS ACCURACY, BETTER UNDERSTAND WHO, WHAT, WHEN, WHERE AND WHY OTHERS MAY ACCESS YOUR HEALTH INFORMATION AND MAKE MORE INFORMED DECISIONS WHEN AUTHORIZING DISCLOSURE TO OTHERS.

YOUR HEALTH INFORMATION RIGHT

ALTHOUGH YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF THE HEALTHCARE PRACTITIONER FACILITY THAT COMPILED IT, THE INFORMATION BELONGS TO YOU. YOU HAVE THE RIGHT TO:

- REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OF YOUR INFORMATION
- OBTAIN A PAPER COPY OF THE NOTICE OF INFORMATION PRACTICES UPON REQUEST
- INSPECT AND OBTAIN A COPY OF YOUR HEALTH RECORD
- AMEND YOUR HEALTH RECORD
- OBTAIN AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH RECORD
- REQUEST COMMUNICATIONS OF YOUR HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS.
- REVOKE YOUR AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN.

OUR RESPONSIBILITIES

THIS ORGANIZATION IS REQUIRED TO:

- MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION
- PROVIDE YOU WITH A NOTICE AS TO OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO INFORMATION WE COLLECT AND MAINTAIN ABOUT YOU
- ABIDE BY THE TERMS OF THIS NOTICE
- NOTIFY IF WE ARE UNABLE TO AGREE TO A REQUESTED RESTRICTION
- ACCOMMODATE REASONABLE REQUESTS YOU MAY HAVE TO COMMUNICATE HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATION.

WE RESERVED THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION WE MAINTAIN. SHOULD OUR INFORMATION PRACTICE CHANGE, WE WILL MAIL A REVISED NOTICE TO THE ADDRESS YOU'VE SUPPLIED US WITH. WE WILL NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION, EXCEPT AS DESCRIBED IN THIS NOTICE.

Signed_____ Date_____

(Signature of Patient/Parent/Patient's legal Representative)

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Jose Sanchez M.D.
Family Practice

Fatima Magina M.D.
Family Practice

Advanced Health Care Directive

Dear Patient,

As your Physician, we are required to ask any patient over the age of 18, if they have an existing Advanced Health Care Directive, so that we can incorporate the information into your medical records. 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!

Patient Name:_____ SS#:_____

Patient Signature:_____ Date:_____

I decline to answer the question Yes No
Do you have an Advanced Health Care Directive? Yes No
If yes, please indicate what type of Directive.

- -Durable power of attorney ___
- -California Natural Death Act ___
- -Living Health Care Will ___
- -Other_____

Will you bring a copy of your Directive into our office for your medical chart? Yes No

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Office Use Only

Type of Health Care Directive Received_____ Date Received:_____
Staff Initials:_____

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CONSENT AND FINANCIAL RESPONSIBILITY

I hereby consent to medical treatment by Jose A. Sanchez, M.D., Fatima C. Magina, M.D.
_____initials

I understand that all fees are due at the time of service unless Jose A. Sanchez, M.D., Fatima C. Magina, M.D. are a contracted provider for my insurance plan, in which case all co-pays, deductibles, and/or patient percentages required by my insurance are due at the time of service. I understand that my medical insurance may not fully pay for my medical bill and I accept full responsibility for all charges that I incur in Jose A. Sanchez, M.D., Fatima C. Magina, M.D.'s care.
_____initials

I understand that I will receive a monthly billing statement for any balance for which I am responsible and that if I fail to pay the "Due From Patient" portion in full by the due date, I will be charged 1.5% interest per month on the unpaid balance.
_____initials

_____ _____
Signature Date

If you wish to have our office bill your insurance company for your incurred charges, you must sign the Assignment of Benefits and Information Release below. This assignment is assumed to apply to all future claims unless you notify us in writing to the contrary.

I hereby authorize my insurance benefits to be paid directly to Jose A. Sanchez, M.D., Fatima C. Magina, M.D., and I accept financial responsibility for any non-covered services. I authorize to release Jose A. Sanchez, M.D., Fatima C. Magina, M.D. any information required to process insurance claims made on my behalf.

_____ _____
Signature Date

If you are signing this agreement as the responsible party for a minor child, please fillout the statement below as indicated.

I, _____, _____, accept full
(Your Name) (Relationship to Patient)

Financial responsibility as described above and consents to medical treatment by to Jose A. Sanchez, M.D., Fatima C. Magina, M.D. For _____, a minor

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)
_____(Patient's 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 providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:
_____
Name
_____
Address
_____ _____ _____
City State Zip Code

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

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, 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)

Psychiatric/Mental Health _____(initial)

Tests for Antibodies to HIV _____(initial)

HIV Diagnosis/Treatment _____(initial)

Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____
Date

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 or 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's Name (PRINT) Date

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____
Witness name Witness signature