Santa Rosa
MEDICAL GROUP

We would like to welcome you to our office!

Patient Information

Please **PRINT** and **COMPLETE** form.

Patient Information:

Last Name _____ First Name _____ Middle _____

Street Address _____ City _____ State _____ Zip Code _____

Phone Number (_____) _____-_____ Cell Phone Number (_____) _____-_____ Date of Birth ____/____/____ Social Security Number _____-_____-_____

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Other:_____

E-mail Address: _____

Employer's Name _____ Employer's Address _____

City _____ State _____ Zip Code _____ Phone Number (_____) _____ - _____

Responsible party, if patient is a minor:

Name of Guardian _____ Relationship to Patient _____ Date of Birth _____ / _____ / _____

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ - _____ - _____ Phone Number (_____) _____ - _____ Sex: ☐M ☐F

In Case of an Emergency, Please Contact:

Name: _____ Relationship: _____ Phone Number: _____

Tricare Subscribers:

Sponsor:_____ Sponsor DOB:_____ Sponsor SSN:_____

Reason for Visit: _____

Are you here to be treated for a job related injury: ☐**Yes** ☐**No**

Are you here to be treated for an auto related injury: ☐**Yes** ☐**No** **Date:** _____

I have read and accept the HIPAA Agreement: ☐Yes ☐No **Notice of Privacy Practices:** ☐Yes ☐No

I consent to treatment for myself or my above listed minor child. I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid for by my insurance or any third party payor within a reasonable amount of time not to exceed 60 days. If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Santa Rosa MEDICAL GROUP

Medical History

Date: _____

Family History

Personal Yes	Personal No		Family Yes	Family No
☐	☐	Asthma	☐	☐
☐	☐	Arthritis	☐	☐
☐	☐	COPD	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Heartburn	☐	☐
☐	☐	Heart Disease	☐	☐
☐	☐	High Cholesterol	☐	☐
☐	☐	High Blood Pressure	☐	☐
☐	☐	Mental Illness	☐	☐
☐	☐	Stroke	☐	☐
☐	☐	Seizures	☐	☐
☐	☐	Cancer	☐	☐

Please describe any "Yes" answers:

Lifestyle/Habits

Alcohol	☐ Yes	☐ No
Caffeine	☐ Yes	☐ No
Cigarettes	☐ Yes	☐ No
Cigars	☐ Yes	☐ No
Coffee	☐ Yes	☐ No
Exercise	☐ Yes	☐ No
Illicit Drugs	☐ Yes	☐ No

Hospitalizations

Hospitalizations ☐ Yes ☐ No

Year: _____ Reason:

Surgeries ☐ Yes ☐ No

Year: _____ Reason:

Blood Transfusions ☐ Yes ☐ No

Year: _____ Reason:

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If so please list the drug:

Do you have any non-drug allergies? ☐ Yes ☐ No

If so please list the allergy:

Pharmacy:

Medication List

☐ None

Reviewed By:

Cancer Screenings

Colonoscopy	☐ Yes	☐ No	Year____
Hemocult	☐ Yes	☐ No	Year____
Mammography	☐ Yes	☐ No	Year____
Pap Smear	☐ Yes	☐ No	Year____
PSA	☐ Yes	☐ No	Year____

Other:

Immunizations

Childhood	☐ Yes	☐ No	Year____
Influenza	☐ Yes	☐ No	Year____
Pneumovax	☐ Yes	☐ No	Year____
Tetanus	☐ Yes	☐ No	Year____

Other:

Is there any other pertinent health information that you would like to list not otherwise noted above? ☐ Yes ☐ No

If yes, please list:

Do you have any religious limitations concerning your health? ☐ Yes ☐ No

If yes, please list:

Patient Name:_____ Date of Birth:_____ M / F

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.

☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. RESEARCH STUDIES:

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____ .

7. CONSENT TO PHOTO/VIDEO:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. E-MAIL:

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. CELL PHONES:

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

ROI

Patient's Name				Date of Birth	Medical Record Number
Address	City	State	Zip	Telephone Number	Email Address

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information				
Address	City	State	Zip	Telephone Number

Agency or Individual(s) Authorized to Receive my Health Information				
Address	City	State	Zip	Telephone Number

Health Information that may be used / disclosed is limited to the following:

☐ Discharge Summary ☐ History and Physical ☐ Consultation(s) ☐ Progress Notes ☐ Emergency Room Record
☐ Operative Note(s) ☐ Imaging/X-Ray Films ☐ X-Ray Reports ☐ Lab ☐ Pathology Report
☐ Other *(specify)* _____ ☐ Entire Record ☐ Fetal Heart Monitor Strips

Sensitive Information: ☐ Alcohol Abuse ☐ Drug Abuse ☐ Communicable diseases, including HIV status
☐ Genetic Testing ☐ Psychiatric/Behavioral Diagnoses

Health Information that may be used / disclosed is limited to the following periods of healthcare:

From (date): _____ To (date): _____ Account Number: _____
From (date): _____ To (date): _____ Account Number: _____

Health information to be released to the above named agency / individual is to be used / disclosed for the following purpose(s):

☐ Treatment/Consultation ☐ At Request of Patient ☐ Research ☐ Marketing ☐ Billing or Claims Payment
☐ At Request of Employer ☐ Other _____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, including Sensitive Information as indicated above, which was compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically *expire 60 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's Signature or Legal Representative			Date/Time
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Utilized	Date/Time
Witness Signature	Date/Time	Expiration Date or Event	

☐ **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records.*
☐ Electronic copy requested.

Authorization to Use and Disclose Protected Health Information
HIM-1401HMS
(Revised 11/10, 02/12, 05/14, 08/14, 04/15, 09/16, 04/17)

Patient Label

Patient's Name	Date of Birth	Medical Record Number	
Patient Street Address	City	State	Zip
Home Telephone Number	Work Telephone Number		

I give permission to VERBALLY discuss the following medical information about me *(check all boxes that apply):*

❑ Medical information, including my symptoms, diagnosis, medications and treatment plan
❑ Lab/test results
❑ Other (describe):_____
❑ Other (describe):_____

The physician practice has my permission to discuss the above information with:

1. _____
Name/Relationship to Patient

Street Address | City | State | Zip

Home Telephone Number | Work Telephone Number

2. _____
Name/Relationship to Patient

Street Address | City | State | Zip

Home Telephone Number | Work Telephone Number

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. **I understand that I must notify the physician practice in writing if I want to revoke my permission.**

Patient's or Authorized Personal Representative's Signature			
Relationship to Patient / Authority to Act on Patient's Behalf	Interpreter, if Utilized	Date	Time
Witness Signature	Expiration Date or Event	Date	Time

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign: _____

Patient Label