La Verne Medical Group – Welcome Packet

Date	First Name	Middle Name	Last Name
Home Phone		Cell Phone	Work Phone
Home Address	City	State	Zip Code
Email Address:			
Social Security #	Birth date: Month/Date/Year	AGE:	☐ MALE ☐ FEMALE
Emergency Contacts: First Name	Last Name	Telephone No.	Relationship

INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

RELEASE OF INFORMATION/ ASSIGNMENT OF BENEFITS FOR LA VERNE MEDICAL GROUP

I hearby authorize the above named provider(s) to disclose when requested by the above named insurance carrier or its representatives any and all information with respect to any illness(es) or injury(ies), medical history or treatment and copies of all medical records. A photocopy of this authorization shall be considered as effective and valid as the original. I authorize payment to the above named provider(s) the amount due in my pending claim for basic medical, major medical, and/or surgical treatment or services by reason of such treatment or services. I have read the information above and hereby give my permission to administer treatment, and to perform such procedures as may be deemed necessary in diagnosis and/or treatment of my condition.

Signature of Patient or Parent/Guardian: ____

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MEDICATION LIST

Patient Name: ____ DOB: _______________

Name Of Medication	Strength	Number of Times Taken

Patients Personal History

TELL US ABOUT YOURSELF!

Home situation:

Single: ___ Married: How Long ____ Divorced: How Long ____ Widowed: How Long___

Employment Status: Full-time ___ Retired ___ Disabled ___ Homemaker ___

Occupation: ______________________________

Habits:

Do you smoke? ________ If yes, how many packs per day? ______ If you have quit, how long ago? _______

Do you use alcohol? ________ If yes, how often do you drink? _______ If you have quit, how long ago? ______

Do you exercise regularly? ________ How often? ________/week What activity? ________

Do you/have you used illicit drugs? ________

Transfusion: Have you ever had a blood transfusion? ________

Immunizations: if yes, give approximate year given

Pneumococcal ________

H. Influenza ________

Hepatitis B (series of 3) ________

Tetaus Booster ________

Shingles ________

Family History: (Place an X in appropriate boxes to identify all illnesses/conditions in your blood relatives)

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Father	Mother	Brother	Sister	Son	Daughter	Other
Colon or Rectal Cancer											
Breast Cancer											
Other Cancer?											
Stroke Before age 65											
Heart Attack Before age 65											
Diabetes											
High Blood Pressure											
High Cholesterol											
Alzheimer's Disease											
Alcohol Abuse											
Drug Abuse											
Depression											
Bipolar Disorder											
Genetic Disorder											

Age of Parents: Mother _____ or Deceased Father _____ or Deceased

Number of Children: _____ Age of Children: ____________________

PAST MEDICAL HISTORY:

Write in the names of any diseases you have had which required hospitalization:

Disease **Hospital** **Year**

____

____

____

____

Write in the name and year of any operations which you have had:

Operation **Hospital** **Year**

____

____

____

____

Serious illness which you have had which **did not** require hospitalization:

____

____

____

Any additional injury or accident: ____

SYMPTOM REVIEW:

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GENERAL (circle)

1. YES NO Do you have fever or chills?
2. YES NO Do you have night sweats?
3. YES NO Have you noticed a recent loss or gain of weight? How much? _____
4. YES NO Have you noticed a change of appetite? (circle) Increase or Decrease
5. YES NO Have you noticed excessive fatigue lately in doing your usual activities?

CARDIOVASCULAR SYSTEM (circle)

A. Do you have chest pains or tightness in the chest which begin: (circle)
   1. YES NO When exerting yourself?
   2. YES NO When walking up hill?
   3. YES NO After a heavy meal?
   4. YES NO When upset or excited?

B. YES NO Do you have palpitations?

C. YES NO Have you noticed ankle or leg swelling?

D. YES NO Do you have chest pain in which
   1. YES NO Radiate down the arm?
   2. YES NO Disappears if you rest?
   3. YES NO Occurs only at rest?
   4. YES NO When walking fast?

CARDIO-RESPRITORY (circle)

A. YES NO Do you have shortness of breath? (circle)
   1. YES NO Doing your usual work?
   2. YES NO Climbing a flight of stairs?
   3. YES NO Which awakens you at night?
   4. YES NO Which causes you to cough?
   5. YES NO Accompanied by wheezing?

B. YES NO Do you have a chronic cough?
   1. YES NO Have you ever coughed blood?
   2. YES NO Do you cough up sputum? How much?

GI TRACT (circle)

A. Have you recently had pain in the stomach which:

1. YES NO Occurs 1-2 hours after a meal?
2. YES NO Is brought on by eating fried foods, greasy foods?
3. YES NO Awakens you at night? What time_______?
4. YES NO Is relieved by antacid medications?
5. YES NO Is relieved with milk or eating?
6. YES NO Occurs while eating or immediately after?
7. YES NO Is relieved by a bowel movement?
8. YES NO Have you recently had a loss of appetite?

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B. If you have had a change in bowel habit recently?
   1. YES NO Crampy pain in abdomen?
   2. YES NO Alternating diarrhea and constipation?
   3. YES NO Pain during or after bowel movements?
   4. YES NO Mucus in the stool?
   5. YES NO Blood in the stool?
   6. YES NO Required use of strong laxatives or enemas?

URINARY SYSTEM (circle)

Do you have:

1. YES NO Burning while urinating?
2. YES NO Loss of control of bladder?
3. YES NO Blood in the urine?
4. YES NO Dark colored uring?
5. YES NO Trouble starting to urinate?
6. YES NO Trouble holding the urine?
7. YES NO Getting up frequently at night? How often? _______
8. YES NO Passed a kidney stone?

GENITAL SYSTEM (circle)

A. To be answered by **WOMEN** only:
   1. YES NO Are you still having regular monthly menstrual periods?
   2. YES NO Have you ever had bleeding between your periods?
   3. YES NO Do you heavy bleeding with your periods?
   4. YES NO Do you feel bloated and irritable before your period?
   5. YES NO Are you now on or have you ever taken birth control?
   6. YES NO Have you ever had miscarriage?
   7. YES NO Have you ever discharged from the nipple on your breast?
   8. YES NO Do you regularly have cancer test of the cervix?
   9. How many children born alive?______ How many miscarriages?______
   10. How many stillbirths? _______ How many cesarean operations? _______
   11. How many premature births?________ Any complications of pregnancy?_______
   12. Date of last menstrual period? _________

B. To be answered by **MEN** only:
   1. YES NO Loss of sexual activity? For how long? __________
   2. YES NO Treatment for genitals? (private parts)
   3. YES NO Discharge from penis?
   4. YES NO Syphilis or Gonorrhea

5. YES NO Prostate trouble?

PERIPHERAL VASCULAR SYSTEM (circle)

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Have you recently had:

1. YES NO Pain in calves of legs when walking?
2. YES NO Cramps in legs at night or doing exercise? (Charlie Horse)
3. YES NO Vericose Veins
4. YES NO Phlebitis or inflamed leg veins?

CENTRAL NERVOUS SYSTEM (circle)

Do you frequently have severe headaches? (If yes answer the following)

1. YES NO Do they cause visual trouble?
2. YES NO Do they occur on one side of the head? Which side?
3. YES NO Do they awaken you at night from sleep?
4. YES NO Do they hurt most in the back of the head and neck?
5. YES NO Have you had an seizures?
6. YES NO Have you ever fainted?
7. YES NO Do you have spells of dizziness?
8. YES NO Do you have weakness of an arm or leg?
9. YES NO Do you have double vision?
10. YES NO Do you have pain in your ears?

HEMATOLOGY (circle)

1. YES NO Do you frequently have bleeding gums?
2. YES NO Do you bruise easily?
3. YES NO Do you have prolonged bleeding from wounds?
4. YES NO Do you have nose bleeds?

MUSCULOSKELTAL SYSTEM (circle)

1. YES NO Any joint pain? Which one?
2. YES NO Any joint swelling? Which one?
3. YES NO Any backache? How long?
4. YES NO Any pain in big toe?

SKIN (circle)

1. YES NO Any skin infections?
2. YES NO Any discoloration?

TB EXPOSURE RISK ASSESSMENT

Please answer the following questions by writing yes/no in the box on the right Y/N

1	Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB?	
2	Do you or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss?	
3	Do you have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?	
4	Were you born in, or travel to high TB prevalence countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)?	

TO BE COMPLETED BY THE MEDICAL STAFF

Administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a Yes response). UNLESS:

1. The patient has a previously documented positive Mantoux TB skin test, or
2. The patient has had a TB skin test within the last year, or
3. The patient has been vaccinated with BCG within the last 12 months.

Reason for TB skin test if other than periodic evaluation:

CIRCLE: WORK SCHOOL TB CONTACT PRENATAL OTHER

NURSE/PROVIDER SIGNAURE: ____

ADVANCE 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 Advance Health Care Directive so that we can incorporate the information into you medical record. You are not required to give us this information, but we are required to ask.

I decline to answer these questions YES _____ NO _____

Do you have an Advance Health Directive? YES _____ NO _____

If yes, please indicate which type of directive:

Durable Power of Attorney for Healthcare _____

California Natural Death Act _____

Living Health Care Will _____

Other? _______________

Printed Patient Name: ____

Signature of Patient or Parent/Guardian: ____________________________________ Date: _________

CONFIDENTIALITY AGREEMENT

Date: ______________________

I, _________________________ give my permission to La Verne Medical Group to share any and all aspects of my medical condition with my family member(s) or care givers as mentioned below.

NAME	RELATIONSHIP
1. ______________________________	___________________________________
2. ______________________________	___________________________________
3. ______________________________	___________________________________
4. ______________________________	___________________________________

Signature of Patient or Parent/Guardian: _______________________________ Date: _________

Physician-Patient Arbitration Agreement

Article I: **Agreement to Arbitrate*:*** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California State Law, and not by a lawsuit or resort to court process expect as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in court of law before a jury, and instead are accepting the use of arbitration.

Article II: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the

time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Article III: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees and witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to dispute within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article IV: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the data notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article V: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article VI: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services **PATIENT INITIALS** _____

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provision shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

Notice: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUES MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE I OF THIS CONTRACT.

SIGNED,

LA VERNE MEDICAL GROUP / LA VERNE MEDICAL URGENT CARE ***September 15, 2017***

Printed Patient Name: ____

Signature of Patient or Parent/Guardian: __________________________________ Date: _________

AUTHORIZATION TO PAY PHYSICIAN

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED DIRECTLY TO:

LA VERNE MEDICAL GROUP / LA VERNE MEDICAL URGENT CARE

1234 FOOTHILL BLVD, LA VERNE, CA 91750

THE MEDICAL AND SURGICAL EXPENSE BENEFITS ALLOWABLE AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY, AS PAYMENT TOWARDS THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. THIS PAYMENT WILL NOT EXCEED MY INDEBTEDNESS TO ABOVE MENTIONED ASSIGNEE AND I HAVE AGREED TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERIVCE CHARGES OVER AND ABOVE THIS INURANCE.

Printed Patient Name: ____

Signature of Patient or Parent/Guardian: _____________________________________ Date: _________

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFOMRATION, PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry on treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It all describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information that may identify you and that relates to you past, present, or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

La Verne Medical Group – Welcome Packet

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services for you, to pay your health care bills, to support the operation of the physcian's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, or training of medical students.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or NeglectL Food and Drug Administration: Legal Proceedings: Military Activity and National Security: Workers' Compensation: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements section 164.500.

Other Permitted and Require Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by the law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request a restriction of your protected health information.

Your physician in not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclose your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location**. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Sevretary of Health and Human Services if you believe your pirvacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice was publishes and becomes effective on/or before September 15, 2017.

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 909-596-4879.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

______________________________	______________________________	________________
Printed Patient Name	**Signature of Patient**	DATE