**LA VERNE MEDICAL GROUP**
1234 FOOTHILL BLVD. LA VERNE, CA 91750
P 909.596.4879 – F 909.596.9199

# - LA VERNE MEDICAL GROUP WELCOME PACKET -

Dear New Patient,

We are pleased to have you at La Verne Medical Group and hope to provide you with a great care experience! In order to do so, we need to know some information about you. Please fill out this Welcome Packet to the best of your ability. Thank you!

Date: _____

Birth date: _____ Age: _____ [ ] Male [ ] Female

First Name: _____ Middle Name: _____ Last Name:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

Social Security #: _____

Emergency Contact: First Name: _____ Last Name: _____

Phone Number: _____ Relationship: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

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

*I hereby 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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**INSURANCE INFORMATION:**

Primary Insurance:

Secondary Insurance:

## MEDICATION LIST:

Patient Name: _____ DOB: _____

| NAME OF MEDICATION: | STRENGTH: | NUMBER OF TIMES TAKEN: |
|---|---|---|
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LA VERNE MEDICAL GROUP
always here, always caring

## PATIENT'S PERSONAL HISTORY:

**Home situation:** *(Please Mark "X")*
[ ] Single [ ] Married - How Long? ____ [ ] Divorced - How Long? ____ [ ] Widowed - How Long? ____

**Employment Status:** *(Please Mark "X")*
[ ] Full-time [ ] Retired [ ] Disabled [ ] Homemaker **Occupation**: _____

**Habits:** *(Please Mark "X")*

1. Do you smoke? [ ] Yes [ ] No
    1. **IF YES**, how many packs per day? _____ If quit, how long ago? _____
2. Do you use alcohol? [ ] Yes [ ] No
    1. **IF YES**, how often do you drink? _____ If quit, how long ago? _____
3. Do you exercise regularly? [ ] Yes [ ] No
    1. **IF YES,** How often? _____/week What activity? _____
4. Do you/have you used illicit drugs? [ ] Yes [ ] No
5. Transfusion: Have you ever had a blood transfusion? [ ] Yes [ ] No
6. Immunizations: If you have received the below vaccinations, please indicate the approximate year received.
    [ ] Pneumococcal Year: _____ [ ] Tetaus Booster Year: _____
    [ ] H. Influenza Year: _____ [ ] Shingles Year: _____
    [ ] Hepatitis B (series of 3) Year: _____

## PAST MEDICAL HISTORY:

**Hospitalizations:** (Please list the condition, hospital, and year below).

| Condition: | Hospital: | Year: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Operations**: (Please list the operation, hospital, and year below).

| Operation: | Hospital: | Year: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

1. _____ 2. _____

Any additional injury or accident: _____

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## ALLERGIES / ADVERSE REACTIONS:

Allergies: Any known allergies (drug, environmental, or food)? [ ] No [ ] Yes

If YES, list: _____

Adverse reactions to vaccines? [ ] No [ ] Yes

If YES, list: _____

## FAMILY HISTORY:

Do any of your blood relatives have the below conditions? **IF YES**, please list the relationship.

*PLEASE INCLUDE **paternal / maternal** classification of the person you list below.

| **CONDITION:** | RELATIONSHIP TO RELATIVE: | **CONDITION:** | RELATIONSHIP TO RELATIVE: |
|---|---|---|---|
| Colon or Rectal Cancer | | High Cholesterol | |
| Breast Cancer | | Alzheimer's Disease | |
| Other Cancer? | | Alcohol Abuse | |
| Stroke (Before age 65) | | Drug Abuse | |
| Heart Attack (Before age 65) | | Depression | |
| Diabetes | | Bipolar Disorder | |
| High Blood Pressure | | Genetic Disorder | |
| Hypothyroid Underactive | | Hyperactive Overactive | |

**AGE OF PARENTS -** Mother: _____ years or [ ] Deceased / Father: _____ years or [ ] Deceased

**CHILDREN -** Number of Children: _____ Age(s) of Children: _____

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# SYMPTOM REVIEW: (Please Circle "YES" or "NO")

**GENERAL:**

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

**CARDIOVASCULAR SYSTEM:**

1. Do you have chest pain? **IF YES**, PLEASE MARK BELOW.
   - (a) YES NO When exerting yourself?
   - (b) YES NO When walking up hill?
   - (c) YES NO After a heavy meal?
   - (d) YES NO When upset or excited?
   - (e) YES NO When walking fast?
   - (f) YES NO Radiate down the arm?
   - (g) YES NO Disappears if you rest?
   - (h) YES NO Occurs only at rest?
2. YES NO Do you have palpitations?
3. YES NO Have you noticed ankle or leg swelling?

**RESPIRATORY:**

1. Do you have shortness of breath? **IF YES,** PLEASE MARK BELOW.
   - (a) YES NO Doing your usual work?
   - (b) YES NO Climbing a flight of stairs?
   - (c) YES NO Which awakens you at night?
   - (d) YES NO Which causes you to cough?
   - (e) YES NO Accompanied by wheezing?
2. Do you have a chronic cough? **IF YES**, PLEASE MARK BELOW.
   - (a) YES NO Have you ever coughed blood?
   - (b) YES NO Do you cough up sputum? How much? _____

**GI TRACT:**

1. Have you recently had pain in the stomach? **IF YES**, PLEASE MARK BELOW.
   - (a) YES NO Occurs 1-2 hours after a meal?
   - (b) YES NO Brought on by eating fried, greasy foods?
   - (c) YES NO Awakens you at night? What time(s)? _____
   - (d) YES NO Is relieved by antacid medications?
   - (e) YES NO Is relieved with milk or eating?
   - (f) YES NO Occurs while eating or immediately after?
   - (g) YES NO Is relieved by a bowel movement?
   - (h) YES NO Have you recently had a loss of appetite?
2. If you have had a change in bowel habit recently?
   - (a) YES NO Required use of strong laxatives or enemas?
   - (b) YES NO Alternating diarrhea and constipation?
   - (c) YES NO Pain during or after bowel movements
   - (d) YES NO Cramp like pain in abdomen?
   - (e) YES NO Blood in the stool?
   - (f) YES NO Mucus in the stool?

**URINARY SYSTEM:**

1. Do you have:
   - (a) YES NO Burning while urinating?
   - (b) YES NO Loss of control of bladder?
   - (c) YES NO Blood in the urine?
   - (d) YES NO Dark colored urine?
   - (e) YES NO Trouble starting to urinate?
   - (f) YES NO Trouble holding the urine?
   - (g) YES NO Passed a kidney stone?
   - (h) YES NO Getting up frequently at night? How often? _____

**GENITAL SYSTEM:**

1. To be answered by **WOMEN** only: (Please see #4 below for Males)
   - (a) YES NO Are you having regular monthly menstrual periods?
   - (b) YES NO Have you ever had bleeding between your periods?

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(c) YES NO Do you heavy bleeding with your periods?
(d) YES NO Do you feel bloated and irritable before your period?
(e) YES NO Are you now on or have you ever taken birth control?
(f) YES NO Have you ever had miscarriage?
(g) YES NO Have you ever discharged from the nipple on your breast?
(h) YES NO Do you regularly have cancer test of the cervix?
(i) How many children born alive?_____
(j) How many stillbirths? _____
(k) How many premature births?_____
(l) Date of last menstrual period? _____
(m) How many miscarriages?_____
(n) How many cesarean operations? _____
(o) Any complications of pregnancy?_____

2. YES NO Loss of sexual activity? For how long? _____
3. YES NO Syphilis or Gonorrhea?

4. To be answered by **MEN** only
   (a) YES NO Loss of sexual activity? For how long? _____
   (b) YES NO Treatment for genitals? (private parts)
   (c) YES NO Discharge from penis?
   (d) YES NO Syphilis or Gonorrhea?
   (e) YES NO Prostate trouble?

**PERIPHERAL VASCULAR SYSTEM:**

1. Have you recently had:
   (a) YES NO Pain in calves of legs when walking?
   (b) YES NO Cramps in legs at night or doing exercise?
   (c) YES NO Varicose Veins?
   (d) YES NO Phlebitis or inflamed leg veins?

**CENTRAL NERVOUS SYSTEM:**

1. Do you frequently have severe headaches? **IF YES**, PLEASE MARK BELOW.
   (a) YES NO Do they cause visual trouble?
   (b) YES NO Do they occur on one side of the head? Which Side? _____
   (c) YES NO Do they awaken you at night from sleep? How often? _____
   (d) YES NO Do they hurt most in the back of the head and neck?
   (e) YES NO Have you had any seizures? How many? _____
   (f) YES NO Have you ever fainted?
2. YES NO Do you have spells of dizziness?
3. YES NO Do you have weakness of an arm or leg?
4. YES NO Do you have double vision?
5. YES NO Do you have pain in your ears?

**HEMATOLOGY:**

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

**MUSCULOSKELETAL SYSTEM:**

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

**SKIN:**

1. YES NO Any skin infections? **IF YES**, please explain: _____
2. YES NO Any discoloration? **IF YES**, please explain: _____

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## 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 Advance Health Care Directive so that we can incorporate the information into you medical record.

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 [ ] Living Health Care Will
[ ] California Natural Death Act [ ] Other: _____

**Printed Patient Name**: _____

**Signature of Patient or Parent/Guardian**: _____ **Date**: _____

## TB EXPOSURE RISK ASSESSMENT:

Please answer the following questions by writing **YES/NO** in the box on the right. **YES/NO:**

| | |
|---|---|
| Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB? | |
| Do you or have you had symptoms of TB, such as cough, chest congestion, fever, night sweats, and/or weight loss? | |
| 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) | |
| Were you born, or travel to high TB prevalence countries (most countries in Asia, Africa, Latin America, and parts of Eastern Europe?) | |

***THIS BELOW PORTION IS TO BE COMPLETED BY MEDICAL STAFF*** *(NOT TO BE FILLED BY PATIENT):*

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:

[ ] WORK [ ] SCHOOL [ ] TB CONTACT [ ] PRENATAL [ ] OTHER: _____

**NURSE/PROVIDER SIGNATURE:** _____ **DATE:** _____

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## CONFIDENTIALITY AGREEMENT:

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. | _____ | _____ |

**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 SERVICE CHARGES OVER AND ABOVE THIS INSURANCE.

**Printed Patient Name**: _____

**Signature of Patient or Parent/Guardian**: _____ **Date**: _____

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# 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:

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

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

**Printed Patient Name**: _____

**Signature of Patient or Parent/Guardian**: _____ **Date:** _____

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# HIPAA NOTICE OF PRIVACY PRACTICES:

**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.**

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.

**Uses and Disclosures of Protected Health Information:**

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 physician'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 & Require Uses & Disclosures** will be made 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 Secretary of Health and Human Services if you believe your privacy 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 acknowledgment that you have received this Notice of our Privacy Practices:

| _____ | _____ | _____ |
|---|---|---|
| **Printed Patient Name** | **Signature of Patient** | **Date** |