

LA VERNE MEDICAL GROUP URGENT CARE

1234 FOOTHILL BLVD. LA VERNE, CA 91750

P. (909) 971-4808



**LA VERNE MEDICAL GROUP &
URGENT CARE**
always here, always caring

- LA VERNE MEDICAL GROUP URGENT CARE 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: _____

[] Male [] Female

Date of Birth: _____

Age: _____

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 Located in Which City: _____

REASON FOR VISIT: _____

LIST ALL INSURANCE: _____

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

I hear by 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(s), 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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PATIENT INFORMATION:

MEDICATION LIST: Patient Name: _____ DOB: _____

NAME OF MEDICATION:	STRENGTH:	NUMBER OF TIMES TAKEN:

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: _____

HABITS:

1. Do you smoke? _____ If yes, how many packs per day? _____

2. Do you use alcohol? _____ If yes, how often do you drink? _____ If you have quit, how long ago? _____

PAST MEDICAL HISTORY:

Hospitalizations:

Condition:	Hospital:	Year:
_____	_____	_____
_____	_____	_____

Operations:

Operation:	Hospital:	Year:
_____	_____	_____
_____	_____	_____

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URGENT CARE CONSENT, ASSIGNMENT, AND RELEASE FORM:

CONSENT FOR MEDICAL TREATMENT

I voluntarily present to La Verne Medical Urgent Care and consent to treatment of the physician on duty and whomever they may designate as their assistant, associate, treating physician and patient care staff to provide my care. Such care may include, but is not limited to, diagnostic procedures, radiology evaluations and procedures, and the administration of medications considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks.

PLEASE INITIAL _____

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of services provided, I hereby assign and transfer to La Verne Medical Urgent Care any and all rights, which I have against insurance companies or third party payers, for payment of charges for services provided by La Verne Medical Urgent Care to me or to one of my dependents. I authorize said payments to be applied to any unpaid balance for which I am responsible. I understand that I am responsible for and will pay the portion of my bill not covered by insurance companies or third party payers. I agree to pay the account in full upon receipt of my billing statement unless payment arrangements are made with La Verne Medical Urgent Care. It is our policy that any insurance co-pays and deductibles or any balance of a bill owed by those without insurance is due at the time of service. **I am responsible for all charges not covered by insurance.**

PLEASE INITIAL _____

GOVERNMENT COMPLIANCE

In compliance with the recently enacted Patient Protection and Affordable Care Act and the Stark Law, La Verne Medical Urgent Care must inform you that there are other options pertaining to laboratory, diagnostic, and radio-graphic services. Specifically it should be noted that you have presented to La Verne Medical Urgent Care voluntarily for your medical needs and that as part of the evaluation of your condition and any required treatment, the physician on duty may determine that particular laboratory, diagnostic, and radio-graphic tests may be needed. La Verne Medical Urgent Care offers many of these services on-site as a convenience to our patients. If any patient would like to have their laboratory or radio-graphic services provided at another location we can provide you with a list of nearby locations.

PLEASE INITIAL _____

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

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RELEASE AND USE OF PATIENT INFORMATION:

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. TREATING PHYSICIANS on staff at La Verne Medical Urgent Care and their staff, agents of another healthcare facility if direct transfer to another facility is required, and to my primary care physician or any referred consultants for follow up care.
2. AN EMPLOYER who requests services. This may include your personal medical history, physical, laboratory and diagnostic tests, and drug screenings (including the presence of drugs, alcohol or marijuana).
3. INSURANCE COMPANY or other third party payer and their agents as well as any review organization or government agency for the purpose of determining eligibility and available benefits, obtaining payment for services provided, and insuring government compliance.
4. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized health care professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.

PLEASE INITIAL _____

I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely effected and that I could be held liable for the full cost of services provided by La Verne Medical Urgent Care. I understand this information may contain my personal medical history, physical, and treatments (if necessary), radio-graphic and laboratory results. I understand that I have the right to revoke this authorization.

_____ I AUTHORIZE LVMUC to release any and all information concerning my medical care to my Primary Care Physician.

- NAME OF PRIMARY CARE PHYSICIAN: _____

_____ I DO NOT authorize LVMUC to release any information concerning my care to any individual.

Printed Patient Name

Signature of Patient

Date