Riverside Family Physicians
Your wellness is our business
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TEL: 951.781.6335 FAX: 951.781.6365
www.famdoc.org

PPC - MEDICAL HOME NCQA RECOGNIZED PRACTICE

Form Instructions: *Please print your responses legibly.*

Date: _____ **Home Phone:** (____) _____

Patient Information

Name: _____ **SS#** _____

Last Name, First Name Middle initial

Address _____ **Cell Phone:** (____) _____

City _____ **State** _____ **Zip code**_____

Gender: □ Female □ Male Age _____ **Birthdate** _____ □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced □ Partnered for _____ years

Primary Language: □ English □ Spanish □ Vietnamese □ Cambodian □ Farsi □ Arabic □ Other _____

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Pacific Islander □White □ Declined to state

Ethnicity: □ Hispanic □ Not Hispanic/Latino □ Declined to state

Patient Employer/ School _____ **Occupation** _____

Employer/School Address _____ **Employer/School Phone** (___)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ **Phone** (____) _____

Relation to Patient: _____

Person Responsible for Account _____

Last Name, First Name Middle initial

Relation to Patient _____ **Birthdate** _____ **SS#**_____

Address (if different from patient(s) _____ **Phone** (___) _____

City _____ **State** _____ **Zip code**_____

Insurance Information

Do you have Medical Insurance? □ Yes □ No If yes please complete below:

Name of Primary Insurer _____ **Policy Holder** _____

Contract # _____ **Group #** _____ **Subscriber #** _____

Name of Secondary Insurer (If any) _____ **Policy Holder** _____

Contract # _____ **Group #** _____ **Subscriber #** _____

Do you have Medi-Cal? □ Yes □ No

Do you have Medicare? □ Yes □No If yes, Medicare # and letter _____

INFORMATION FOR PERSON COMPLETING THIS FORM

_____	_____	_____	_____
Name	**Signature**	**Relation to Patient**	**Date**

HEALTH QUESTIONNAIRE

Name_____ D.O.B. _____ Date_____

Past Medical History

Stroke……	No	Yes
Heart disease……	No	Yes
Kidney disease……	No	Yes
Cholesterol……	No	Yes
High Blood Pressure……	No	Yes
Diabetes……	No	Yes
Thyroid……	No	Yes
Have you had any serious illness?……	No	Yes
Have you ever been hospitalized or been under medical care for very long?……	No	Yes

If yes for what reason? _____

Surgeries:

Have you had any surgery?…… No Yes

List _____ _____

_____ _____

Social History:

Lives with: _____

Marital Status: Single Married Separated Divorced Widowed

Do you have dependents at home? _____

Alcoholic Beverages: Never_____ Rarely_____ Moderately_____ Daily_____ Ever_____

Caffeine Intake: None _____ Two Caffeine Beverage_____ Heavy Caffeine_____

Illicit drug:…… No Yes

Smoking: Non-Smoker_____ Ex-Smoker_____ Smoker_____

Passive smoking:…… No Yes

Your occupation: _____

Occupational exposure to respiratory irritants:…… No Yes

Exercise: …… No Yes

Family History:

Indicate if your mother, father, brother(s), sister(s) have or had one or more.

Breast Cancer:	mother father brother sister aunt grandparents none
Colon Cancer:	mother father brother sister grandparents none
Stroke:	mother father brother sister grandparents none
Diabetes:	mother father brother sister grandparents none
Heart Disease:	mother father brother sister grandparents none
High Cholesterol:	mother father brother sister grandparents none
Hypertension:	mother father brother sister grandparents none
Kidney Disease:	mother father brother sister grandparents none
Thyroid Problem:	mother father brother sister grandparents none

ADVANCE DIRECTIVE QUESTIONNAIRE

1. Have you formulated an Advance Directive? Yes _____ No _____

2. If you have formulated an Advance Directive, please check the type that you have.

   _____ Durable Power of Attorney for Health Care
   _____ California Natural Death Act
   _____ Living Health Care Will
   _____ Other: _____

3. If you have formulated an Advance Directive, you hereby agree to furnish _____ _____ with a copy within _____ days.

4. If you have change, amend, alter or cancel your Advance Directive, you hereby agree to Notify _____ and provide _____ With a copy as soon as possible so that your physician will be able to comply with your wishes.

5. Expiration date of Advance Directive, if any _____

   (If the Advance Directive was formulated before 1991, it is "good" for only seven years. Advance Directive formulated after 1991, are "good" indefinitely; unless you Change/amend/cancel the Advance Directive.)

6. I would like more information about Advance Directive. Yes _____ No _____

Patient Signature: _____ Date: _____

Patient's name: _____ D.O.B.: _____

RIVERSIDE FAMILY PHYSICIANS

Signature Form

Patient Name (Printed):_____ **Patient Date of Birth:** _____

If Patient Representative, Name (Printed):_____

If Patient Representative, Relationship to Patient (Printed): _____

Acknowledgement of Receipt of Notice of Privacy Practices:

Your name and signature on this sheet indicate that you have received a copy of Riverside Family Physicians' Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Riverside Family Physicians'' Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the as indicated on your Notice.

Authorization of treatment and financial agreement:

I authorize treatment for myself and/or patient. I agree to pay for all fees and charges for such treatment at the time they are incurred, unless previous arrangements have been made in advance. I authorize Riverside Family Physicians o use any and all medications and/or anesthesia deemed necessary during the course of treatment up to and including emergency services

Authorization to pay benefits to physician:

I hereby authorize payment directly to Riverside Family Physicians for medical/Surgical Benefits otherwise afforded me. I authorize Riverside Family Physicians to release any and/all medical records to my Insurance Company which are deemed necessary to secure payments for service rendered

I hereby assign to Riverside Family Physicians any insurance or other third-party benefits available for health care services provided to me. I understand that Riverside Family Physicians has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Riverside Family Physicians, I agree to forward to Riverside Family Physicians all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

You may share information about my condition with: (Please list Name Below)

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ _____

Signature of Patient/Legal Guardian/Patient Representative **Date**

_____

Date Notice Received

RIVERSIDE FAMILY PHYSICIANS
Information on Patient Rights Under HIPAA

Notice of Privacy Practices

This information is to help you understand your rights under federal privacy regulations, the Health Insurance Portability and Accountability Act, or HIPAA. This page focuses on your right to receive a Notice of Privacy Practices (Notice).

What is a Notice of Privacy Practices?

The Notice of Privacy Practices, or Notice, describes the Riverside Family Physician's (RFP) privacy practices. It describes how we use or disclose your medical or health information. It also explains your rights as a patient under privacy regulations, as well as the Health Science Center's responsibilities regarding your information.

Why do I need a Notice of Privacy Practices?

We are required by federal regulations to maintain the privacy of your medical or health information. We create a record of the care and services you receive at RFP. We need this record to provide you with quality care and to comply with certain legal requirements. The Notice will help you understand how to exercise your rights regarding your health information.

How do I get a copy of the Notice?

At your first visit to RFP after April 14, 2003, staff should give you a copy of the Notice. Or, you may call the RFP's, and we will send you a copy in the mail.

How do I get more information about certain rights discussed on the Notice?

For additional information on your rights from the list below, you may:

1. Ask an RFP staff member for forms or written information when available.
2. In the coming months, information will be available on the RFP website at www.famdoc.org under the section titled "Patient Rights Under HIPAA" by clicking on the topic in which you are interested:

- Right to access. *(Information on how to inspect and obtain a copy of your health information.)*
- Right to accounting of disclosures. *(Information on how to request an accounting of disclosures made on your health information.)*
- Right to amendment. *(Information on how to request an amendment to your health information.)*
- Right to request confidential communications. *(Information on how to request that we communicate with you about your health information at alternative locations.)*
- Right to restrictions. *(Information on your right to restrict certain disclosures of your health information.)*
- Right to complain for privacy rights violations. *(Information on your right to complain if you feel that we have used or disclosed your health information inappropriately.)*
- Using and disclosing your health information. *(Information on the ways in which the RFP uses and discloses your health information for treatment, payment, and health care operations. Information on authorizations to release medical or health information and revoking authorizations.)*

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PATIENT FINANCIAL POLICY

[*Patient Name*: _____ *Patient Date of Birth*: _____]

Thank you for choosing Riverside Family Physicians, APMC, as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of your Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies or your responsibilities.

RETURNED CHECKS POLICY

There is a **$25.00 fee** that will be applied to your account for all returned checks. After two returned check events from you the group will no longer be able to accept checks as a valid form of payment with alternative forms of payment being (a) cash or (b) credit/debit card with proper identification.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

DELINQUENT ACCOUNTS POLICY

Should your account become 60days delinquent finance charges of 10% per month may be added to your bill. Services may be discontinued and your bill may be turned over to a collection agency if your account becomes delinquent. It is our office policy that all past due accounts be sent 2 statements. If payment is not made on this account or you have not called to make payment arrangements, the account will be sent to the collection agency and/or attorney, as well as possibly discharged from the practice. Should that happen you will be responsible for payment of all legal and other applicable collection costs. Additionally, we will not be able to continue your care unless the balance is paid in full.

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.

CO-PAYMENTS POLICY

All co-payments are due at time of check-in unless prior arrangements have been made with one of our Business Office staff members. If you did not make prior arrangements with our Business Office and are unable to pay your co-payment your options are to:

a) Reschedule your appointment (**Cancellation Policy** applicable here),
b) Authorize your co-payment be billed to you with a **$10 processing**,
c) Confirm office has sufficient time to see you later in the day after you have secured your co-payment

Please initial here_____acknowledging you read, had an opportunity to ask questions and understand the above.