Riverside Family Physicians, APMC
3975 Jackson Street, Suite 301, Riverside, CA 92503
161 Mckinley St, #105, Corona, CA 91719
4310 Orange Street, Riverside, CA 92501
Phone: (951) 781-6335

Fecha _____ (Please Print) Telefono (____) _____

Información para el Paciente

Nombre _____ SS# _____
Nombre Del Paciente (Completo)

Direccion _____ Cellular (____) _____

Ciudad _____ Estado _____ Zona Postal _____

Sexo □F □ M Edad _____ Fecha De Nacimiento _____ □ Casado □ Viudo □ Unico □ Menor □ Separado □ Divorciado □ Otro _____

Lenguage Primario □ Ingles □ Español □ Otro _____

Raza: □Blanco □Negro □Asia □La India □Las islas del Pacifico □Otro _____ Etnia: □Hispano □No-Hispanos

Empleo/Escuela del Paciente _____ Occupacion _____

Dirrecion Empleo/Escuela_____ Telefono Empleo/Escuela (___)_____

En caso de emergencia que debe ser notificada? _____ Telefono (____) _____

Relación con el Paciente _____

Persona responsable de la cuenta _____
Nombre Completo

Relación con el Paciente _____ Fecha De Naciemiento _____SS#_____

Dirección (si es diferente a la del paciente (s) _____Telefono(___) _____

Ciudad _____ Estado _____ Zona Postal _____

Información del Seguro

Tiene seguro médico? □ No □ Si En caso afirmativo

Nombre de la aseguradora primaria _____Titular de la póliza _____

Contrato _____ Grupo # _____ # Suscriptor _____

Nombre de la aseguradora secundaria (si lo hay) _____Titular de la póliza _____

Contrato _____ Grupo # _____ # Suscriptor _____

Está usted en el Programa Medi-Cal? □ Si □ No Medicare/Medi-Cal □ Si □ No
Tiene Medicare □ Si □No # Medicare y la letra _____

Consentimiento Para Tratamiento Medico:
Consiento en los examenes, evaluaciones, vacuna, tratamientos y procedimientos para el cuidado del paciente susodicho. Comprendo que los asistentes medico (Riveride Family Physicians) han sido aprobado por el Estado de California para dispensar las drogas y los material medicos a las ordenes directas del medico o de acuerdo con las ordenes escribidas, y que siempre u medico esta disponible a los asistentes para la consulta durante la evaluacion y tratamiento del paciente.

Consintimiento para Dar Informacion Sobre su Salud
A tal grado necesario que determinar la responsibilidad a pagar y que obtener los reembolsos, authorizo a Riverside Family Physicians que den ciertas partes de mi historial medica qualquiera persona, organizacion o agencias que seria responsible para alguna porcion de los costos (incluyendo companias de seguros, planes de servicios de salud, agencias de compensacion por lesiones del trabajo, u agencias del gobierno).

Acuerdo Financiero:
Estoy de acuerdo en ser responsible por todos los costos que resultan de estas visitas, sin hacer caso de seguro.

_____ _____
Firma del Paciente, Padre, Tutor o Representante Personal **Fecha**

Encuesta De La Salud

Nombre del Paciente _____ Fecha De Nacimiento _____

Historia Medica Pasada

Problemas del corazon……..	No	Si
Problemas de los rinones……..	No	Si
Colesterol……..	No	Si
Presion alta……..	No	Si
Diabetes ……..	No	Si
Tiroides……..	No	Si
Ha tenido alguna enfermedad seria? ……..	No	Si
Ha Sido hospitalizado o estado bajo cuidado medico por mucho tiempo……	No	Si

Si respondio si, cual fue la razon?_____

Cirugias

Ha tenido alguna cirugia?……..	No	Si

Nombre las cirugias que ha tenido…

_____ _____

_____ _____

Historia Social

Circule uno: Soltero/a Casado/a Separado/a Divorciado/a Viudo/a

Con quien Vive:_____

Cuantos Hijos Tiene:_____

Bebidas Alcolicas: Nunca_____ Algunas Veces_____ Moderadamente_____ Diariamente_____

Cafeina: Nunca _____ Algunas Veces _____ Moderadamente _____ Diariamente _____

Drogas Ilicitas: ……..	No	Si

Fuma: No Fuma____ Fumaba____ Fuma____

Es expuesto a humo de seguna mano: ……..	No	Si

En que trabaja:_____

Es expuesto a irritantes respiratorios?……..	No	Si
Hace ejercisio: ……..	No	Si

Historia Familiar

Porfavor indique si :

Cancer del seno:	Madre Padre Hermano Hermana tia Abuelos NO
Cancer del colon:	Madre Padre Hermano Hermana Abuelos NO
Ataques:	Madre Padre Hermano Hermana Abuelos NO
Diabetes:	Madre Padre Hermano Hermana Abuelos NO
Problemas del corazon:	Madre Padre Hermano Hermana Abuelos NO
Colesterol alto:	Madre Padre Hermano Hermana Abuelos NO
Presion alta:	Madre Padre Hermano Hermana Abuelos NO
Problemas con los rinones:	Madre Padre Hermano Hermana Abuelos NO
Problemas de la tiroide:	Madre Padre Hermano Hermana Abuelos NO

DIRECTIVA AVANZADA PARA LA SALUD

Estimado Paciente,

Como su Médico, tengo la obligacion de pedirle a todos mis pacientes mayors de los 18 años, si ya ha formulado unda Directiva Avanzada para la Salud, asi poder incorporarla a su expediente Médico. No esta obligado ha proporcionar esta informacion, pero si tenemos que pedirsela. Favor de regresar esta forma a la recepcionista al completarla.

Gracias.

1. Reuso contester estas preguntas. ☐Si ☐No

2. Ha formulado usted una Directiva Avanzada? ☐Si ☐No

3. Si ya ha formulado una Directiva Avanzada marque el tipo que tiene.

- Durable Power of Attorney for Health Care ☐
- California Natural Death Act ☐
- Living Health Care Will ☐
- Otro: _____

4. Acepta entregarnos una copia de su Directiva? ☐Si ☐No

5. Le gustaria obtener mas informacion acerca de Los Directivos Avanzados. ☐Si ☐No

Firma Del Paciente _____ Fecha _____

Nombre Del Paciente _____

Fecha De Nacimiento _____

Riverside Family Physicians

Nombre de Paciente (Manuscrito): _____ **Fecha de Nacimiento: _____**

Nombre de Representante (Manuscrito): _____

Relación del Paciente (Manuscrito): _____

Reconocimiento Sobre Recibo de Nota Prácticas Privadas

Adjunto encontrara Nota de Prácticas Privadas. Su nombre y firma en esta pagina indicara que usted a recibido una copia de Riverside Family Physician' Nota de Prácticas Privadas en la fecha indicada. Si usted tiene alguna pregunta sobre la información en la Nota de Prácticas Privadas de Riverside Family Physicians, por favor pregunte al personal de la clínica.

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Acuerdo Financiero:

Estoy de acuerdo en ser responsible por todos los costos que resultan de estas visitas, sin hacer caso de seguro.

Usted puede compartir información acerca de mi condición de: (Por favor escriba el nombre abajo)

Nombre: _____ Relacion al Paciente: _____

Nombre: _____ Relacion al Paciente : _____

Nombre: _____ Relacion al Paciente: _____

_____ _____

Firma Del Patient/Guardian Legal/Representante Del Paciente **Fecha**

_____

Fecha de la notificación fue Recibida

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PPC - MEDICAL HOME NCQA RECOGNIZED PRACTICE

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.

FORM COMPLETION POLICY

For patient requesting forms to be completed by our practice there will be a fee of **$10 per page**—*with few exceptions*—in addition to applicable office visit fees. For example, if you request your physician to complete a two-page, double sided form for your employer the form completion fee charge will be $40, in addition to applicable office visit fees.

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

MEDICAL RECORDS RELEASE POLICY

It is the policy of Riverside Family Physicians, APMC to charge for requested copies of a patients' medical records. A reasonable fee may include actual costs for copying, labor, mailing, shipping or delivery. A medical release form must be properly completed prior to medical release request being processed.

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

I, _____, have read, understand, and agree to the provisions of this Patient Financial Policy Form. I understand that this policy replaces any prior financial policy signed and will be strictly enforced.

Authorization for treatment and financial agreement

I authorize treatment for myself and/or patient. I agree to pay fees and charges for such treatment at the time they are incurred, unless previous arrangements have been made in advance. If I have health insurance I agree to bring my health insurance card and government identification to every visit, as well as confirm that I am eligible for coverage on the date of visit. I authorize Riverside Family Physicians, APMC to 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 physicians

I hereby authorize payments directly to Riverside Family Physicians, APMC for Medical/Surgical Benefits otherwise afford me. I authorize Riverside Family Physicians, APMC to relates any/all medical records to my insurance company which are deemed necessary to secure payment for services rendered.

_____	_____	_____	_____
Patient/Guardian Signature	**Patient/Guardian Name**	**Date of Birth**	**Date**

_____	_____	_____
Witness Signature	**Witness Name**	**Date**

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PPC - MEDICAL HOME NCQA RECOGNIZED PRACTICE

PATIENT COMMUNICATION 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 Communication Policy is important to our professional relationship. Please understand that the way we communicate with each other is a part of that relationship. Please ask if you have any questions about our policies or your responsibilities.

CELL PHONE USE IN OFFICE POLICY

For patient safety and confidentiality purposes we ask that your cellular phone be in (a) silent mode (not vibrate), or (b) powered off while in our facilities. Our group appreciates your immediate compliance with this policy.

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

PRACTICE TO PATIENT COMMUNICATION POLICY

For patient safety and confidentiality purposes our practice will need to communicate to you—i.e. laboratory results, visit follow-up. We require that you check the following boxes for all approved communication methods with you regarding your care, as well as your preferred method:

☐ Phone, Preferred communication method: ☐ Yes ☐ No, if yes, phone:_____
☐ Mail, Preferred communication method: ☐ Yes ☐ No
☐ Email, Preferred communication method: ☐ Yes ☐ No, if yes, email address: _____
☐ Webview/Patient Portal, Preferred communication method: ☐ Yes ☐ No

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

WEBVIEW PATIENT WEBPORTAL POLICY

Webview Patient Web portal is an exciting method of:

- ✓ having updated and around the clock access to important information in your medical record
- ✓ using a secure means of communicating with your healthcare provider

All patients using Webview Patient Web portal agree to the following rules of use:

1. I the Patient understand that the web portal is **NOT** to be used for urgent or emergency situations. In the event of an emergency I will call emergency medical services or 911.
2. I the Patient understand that it may take 72 hours to receive a response to an email request. If I do NOT receive a response within 72 hours I will contact Riverside Family Physicians at (951) 781-6335.
3. I the Patient understand that if I lose my password or username, I may request a new one by calling (951) 781-6335 or in person at one of the Group's locations by providing valid identification.

4. I the Patient understand that I should remember to log out and close my browser when I am finished accessing password protected Portal services. This prevents someone else from accessing my personal information if I leave, share, or use a public computer (i.e., like a library, kiosk, or internet café).
5. I the Patient understand that the terms and conditions of this disclaimer and user agreement may change periodically. Such modifications will take effect immediately upon posting on the web site. I understand that I should review this agreement routinely for changes and modifications.
6. I the Patient hereby agrees to indemnify, defend, and hold harmless the Group and its agents, employees, successors and assigns from and against any and all actions, claims, suits, demands, damages, judgments, losses, and any other costs, liabilities, and expenses, including reasonable attorneys' fees and collection costs, arising from any act, error, or omission of the Group and the provision of or failure to provide any of the Services within the scope of the Web Portal duties as outlined in this Agreement, including but not limited to, advisory and consulting services.
7. I understand that this Agreement is designed to, and by express agreement between the parties, does in fact, reach as far as California law permits.

Enroll in Webview/Patient Portal at this time? ☐ Yes ☐ No

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

I, _____, have read, understand, and agree to the provisions of this Patient Communication Policy Form. I understand that this policy will be strictly enforced.

By signing this agreement I understand and agree to all the terms and conditions in this agreement. The invalidity of any provision(s) or portions of provision(s) of this Agreement shall not affect any other provision(s) or portions thereof. In the event that one or more provisions (or portions thereof) of this Agreement are declared legally invalid, the remainder of this Agreement shall remain in full force and effect, Changes in the law affecting the terns of this Agreement shall be deemed incorporated upon their effective date. I understand that the availability and functionality of this web portal may change without prior notice. I understand and agree to not to hold Riverside Family Physicians, APMC nor its employees or officers liable for any unanswered Patient Portal requests or messages.

_____	_____	_____	_____
Patient/Guardian Signature	**Patient/Guardian Name**	**Date of Birth**	**Date**

_____	_____	_____
Witness Signature	**Witness Name**	**Date**

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Dear Valued Patient,

Riverside Family Physicians is dedicated to providing the highest quality of care to our patients. In an effort to improve the continuity of your care we are implementing Webview*. This Internet accessible web portal allows our patients access to their charts along with a host of other features. It is HIPAA compliant and therefore a safe and secure way to communicate with your healthcare provider. WebView is seamlessly integrated with our electronic medical record system. Along with granting you access to your chart from the comfort of your home or office, WebView gives you many convenient features.

FEATURES:

- ✓ Message your provider or any other office staff member
- ✓ View your prescriptions and request refills through messaging
- ✓ View your health record
- ✓ View your lab results

To login in to our patient portal go to our website www.famdoc.org and click on patient login. You can receive your username and password by in person at our office. If you have any questions or comments, please feel free to contact our office at (951)781-6335.

Kindest Regard,

Your Riverside Family Physicians Healthcare Team

*Webview is a product McKesson Practice Partner Product

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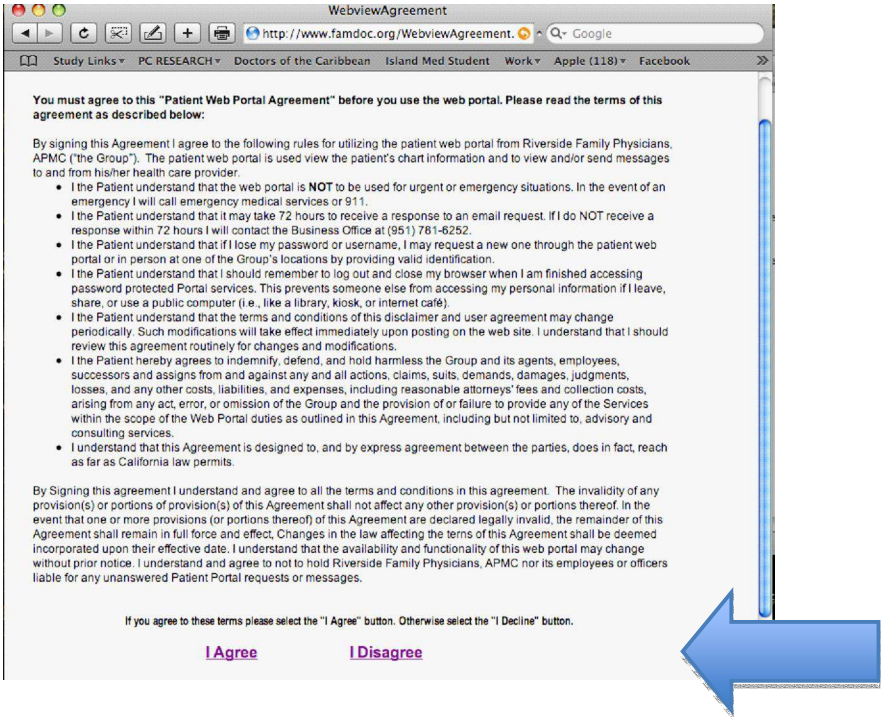
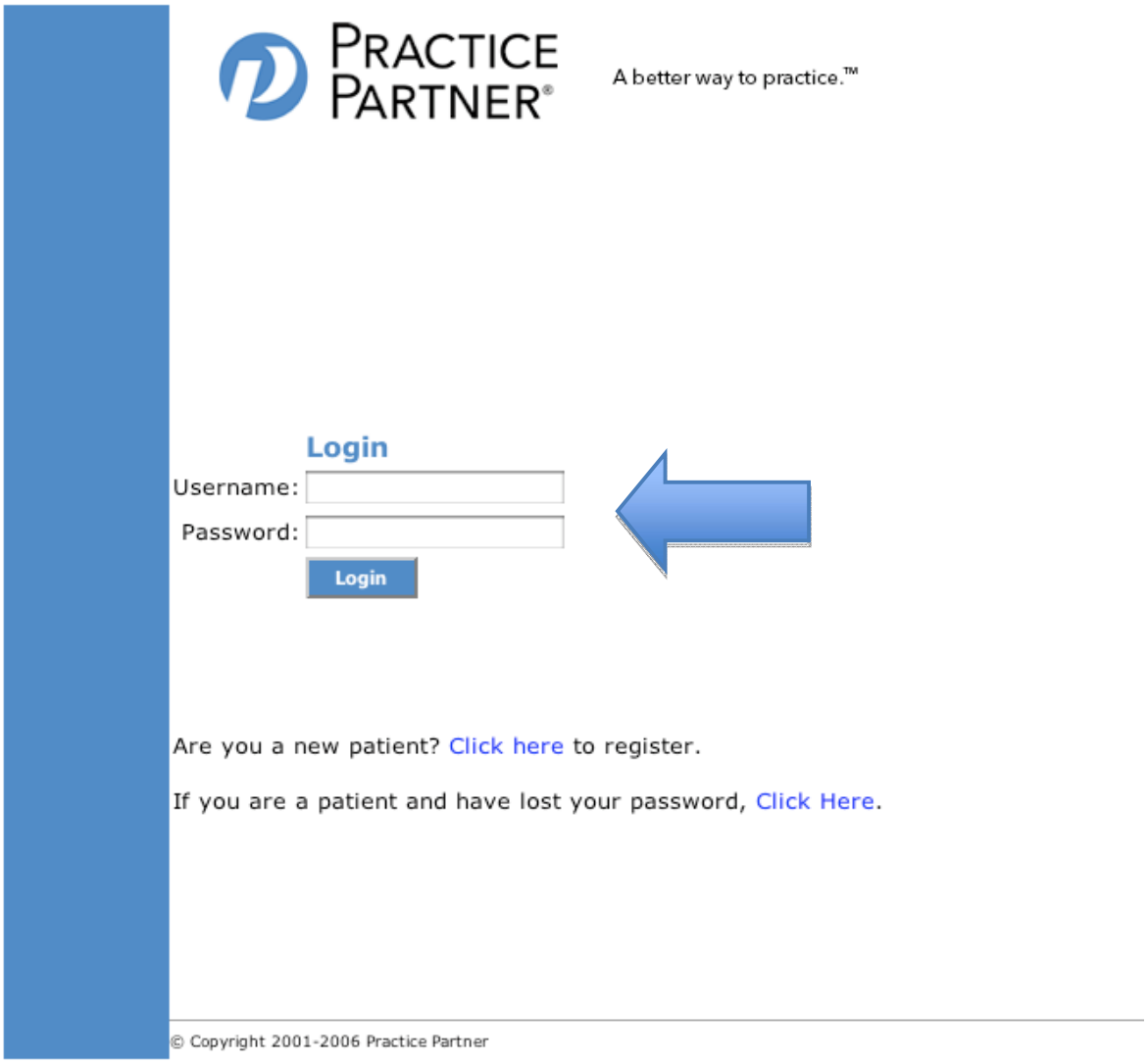
Webview Patient Portal Login Instructions

1. **Go to www.famdoc.org, then select "Patient Login"**

2. **Read and Accept the Terms and Conditions**



3. **Enter your username and password**



USERNAME: _____

TEMPORARY PASSWORD:_____

PASSWORD:_____

PLEASE DO NOT SHARE YOUR PASSWORD OR USERNAME WITH ANYONE.