Riverside Family Physicians
Your wellness is our business
4310 Orange Street, Riverside, CA 92501
4244 Riverwalk Parkway, Suite 150, Riversite, CA 92505
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**

CHILD HEALTH HISTORY

PATIENT NAME: _____ **D.O.B.** _____

HISTORY OF PREGNANCY WITH THIS CHILD:

During which month of pregnancy did you first see the doctor?_____Month
How long was your pregnancy? _____Months
Where was baby born? _____
If baby was born at home, were blood tests for newborn screening done? ☐ Yes ☐ No

Did you have any illnesses or problems? (including sexually transmitted or other communicable diseases)	YES	NO	Did you use any non-prescribed drugs? (tobacco, alcohol, "street drugs:, over-the-counter or home remedies)	YES	NO
Did you take any medications prescribed by your doctor?	YES	NO	Did the baby go home with you from the hospital?	YES	NO
Did you have a difficulty/abnormal delivery/C-section?	YES	NO	Was more than one baby born?	YES	NO
Did the baby have any problems during the 1st week of life?	YES	NO	Did baby receive any shots for Hepatitis B?	YES	NO

CHILD'S HISTORY: ☐ Male ☐ Female Is this child adopted? ☐ YES ☐ NO Birth Weight: _____pounds _____ounces Length: _____ inches

Has your child ever had (Please circle Yes or No):

Measles, Chickenpox, Mumps, Rubella	YES	NO	Vomiting after eating, refusal to eat	YES	NO
Tuberculosis or positive TB Test	YES	NO	Muscle, joint or bone problems	YES	NO
Tonsillitis/Sore Throat	YES	NO	Skin problems	YES	NO
Problems with eyes or vision	YES	NO	Headaches or dizziness	YES	NO
Problems with ears or hearing	YES	NO	Convulsions, seizures, epilepsy	YES	NO
Difficulty breathing/snoring at night	YES	NO	Diabetes	YES	NO
Heart problems	YES	NO	Thyroid problems	YES	NO
Asthma, bronchitis, or pneumonia	YES	NO	Allergies	YES	NO
Anemia, bleeding problems, blood transfusions	YES	NO	Problems with development of school performance	YES	NO
Stomachaches	YES	NO	Serious illness or accident	YES	NO
Diarrhea, Soiling self with stool	YES	NO	Surgery or hospitalization	YES	NO
Bladder Kidney Problems, Wetting self or bed	YES	NO	(GIRLS) Has she stared her periods?	YES	NO
Constipation	YES	NO	(GIRLS) Are there problems with her periods?	YES	NO

FAMILY HISTORY: Does mother (M), father (F), brother (B), sister (S), aunt (A), uncle (U), or grandparent (GP) have:

			Which Family Member?				Which Family Member?
YES	NO	Diabetes		YES	NO	High blood pressure	
YES	NO	Epilepsy or convulsions		YES	NO	Bleeding disorder	
YES	NO	Mental retardation		YES	NO	Tuberculosis	
YES	NO	Heart disease		YES	NO	Allergy	
YES	NO	Cancer		YES	NO	Lung or breathing problems	
YES	NO	Kidney or urinary disease		YES	NO	Eye disorder	
YES	NO	Bone or joint problems		YES	NO	Ear disorder	

PARENT INFORMATION:

	Mother:	Father:
Age:		
Height:		
Occupation:		

HOUSEHOLD INFORMATION: Number of people in home _____
Are both parents living in the home? ☐ Yes ☐ No
Does anyone in the home smoke, or use drugs or alcohol? ☐ Yes ☐ No
Language spoken in the home: _____
Do you live in a: ☐ House ☐ Apartment ☐ Mobile Home ☐ Shelter ☐ Homeless

Patient Identification:

Signature: _____ Date: _____

Relationship to Child: _____

Reviewer's
Signature: _____ Date: _____

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.

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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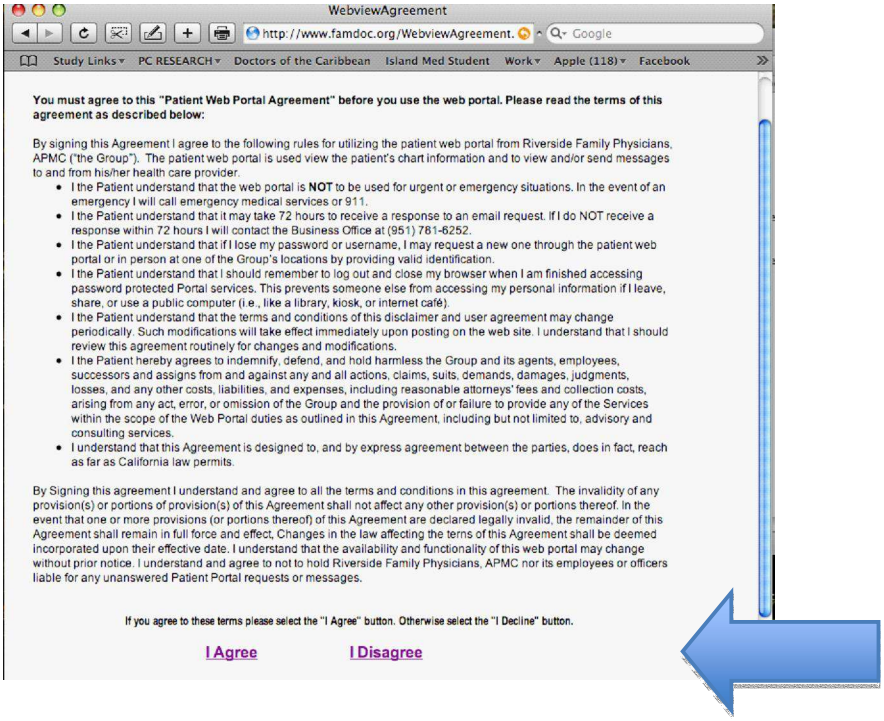
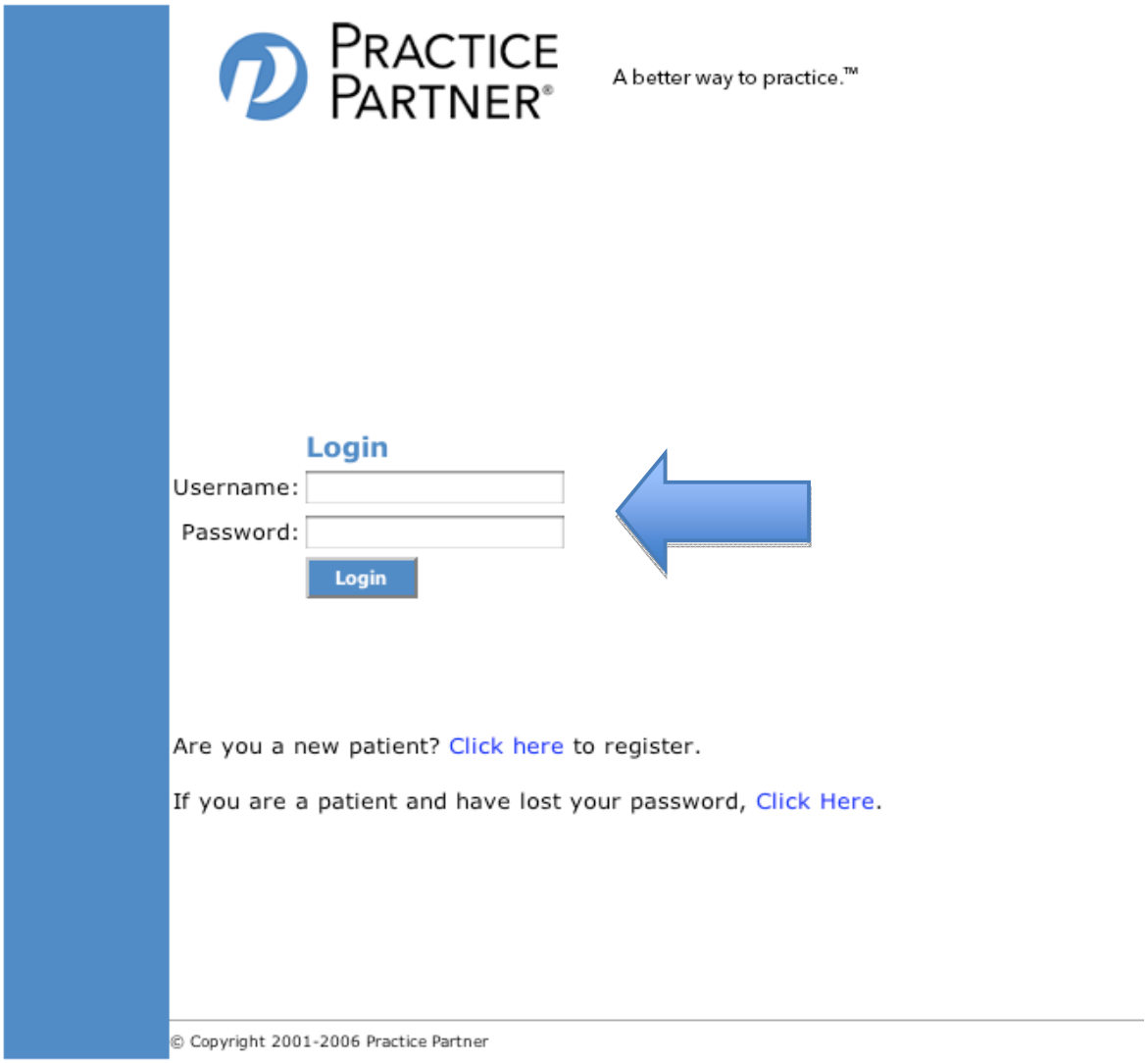
Webview Patient Portal Login Instructions

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.