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**

HISTORIAL DE SALUD DEL NIÑO

NOMBRE DEL PACIENTE _____ **FECHA DE NACIMIENTO** _____

HISTORIAL DE SU EMBARAZO CON ESTE NIÑO:

¿En cuál mes de embarazo visitó al doctor por primera vez?_____Mes ¿Cuánto duró su embarazo? _____Meses			¿Dónde nació el bebé? _____ Si nació en casa, ¿hicieron pruebas de sangre para neonatos? ☐ Si ☐ No		
¿Tuvo enfermedades ó problemas? (inclusive las trasmitidas sexualmente u otras contagiosas)	SI	NO	¿Usó algún medicamento sin receta? (tabaco, alcohol, "drogas", remedios caseros ó sin necesidad de receta)	SI	NO
¿Tomó algún medicamento recetado por su médico?	SI	NO	¿Salieron usted y su bebé juntos del hospital?	SI	NO
¿Tuvo un parto difícil/anormal/intervención Cesárea?	SI	NO	¿Nació más de un bebé?	SI	NO
¿Tuvo su bebé algún problema durante su 1era semana de vida?	SI	NO	¿Recibió su bebé alguna inyección para Hepatitis B?	SI	NO

HISTORIAL DEL NIÑO: ☐ Varón ☐ Hembra ¿Se adoptó este(a) niño(a)? ☐ SI ☐ NO Peso al Nacer: _____libras _____onzas Estatura: _____ pulgadas

¿Ha tenido este(a) niño(a) alguna vez? (Favor de colocar un círculo en Si ó No):

Sarampión, Varicela, Paperas, Rubéola	SI	NO	Vómito después de comer, se niega a comer	SI	NO
Tuberculosis ó análisis de TB positivo	SI	NO	Problemas de músculo, articulaciones ó huesos	SI	NO
Amigdalitis/Dolor de Garganta	SI	NO	Problemas de la piel	SI	NO
Problemas con los ojos ó la visión	SI	NO	Dolores de cabeza ó mareos	SI	NO
Problemas con los oídos ó la audiencia	SI	NO	Convulsiones, ataques de apoplejía, epilepsia	SI	NO
Dificultad respirando/roncando de noche	SI	NO	Diabetes	SI	NO
Problemas del corazón	SI	NO	Problemas de tiroides	SI	NO
Asma, bronquitis, ó pulmonía	SI	NO	Alergias	SI	NO
Anemia, problema de sangrado, transfusiones de sangre	SI	NO	Problemas con desarrollo en la escuela	SI	NO
Dolores estomacales	SI	NO	Enfermedad ó accidente serio	SI	NO
Diarrea, Ensuciarse con su propio excremento	SI	NO	Cirugía ú hospitalización	SI	NO
Problemas de Vejiga, Riñones, Orinarse en sí ó la cama	SI	NO	(NIÑAS) ¿Ha comenzado a menstruar?	SI	NO
Estreñimiento	SI	NO	(NIÑAS) ¿Hay problemas con sus menstruaciones?	SI	NO

HISTORIAL DE FAMILIA: ¿Tienen la madre (M), padre (F), hermano (B), hermana (S), tía (A), tío (U), ó abuelo(a) (GP) :**Favor de colocar un círculo en Si ó No)**

			¿Cuál Miembro de Familia?				**¿Cuál Miembro de Familia?**
SI	NO	Diabetes		SI	NO	Presión arterial alta	
SI	NO	Epilepsia ó convulsiones		SI	NO	Problemas Sanguíneos	
SI	NO	Retardo Mental		SI	NO	Tuberculosis	
SI	NO	Enfermedad del corazón		SI	NO	Alergia	
SI	NO	Cáncer		SI	NO	Prob. de pulmón ó respiración	
SI	NO	Enferm. del riñón ó urinario		SI	NO	Desórdenes de los ojos	
SI	NO	Problemas de huesos ó articulaciones		SI	NO	Desórdenes del oído	

DATOS DE LOS PADRES:

	Madre:	Padre:
Edad:	_____	_____
Estatura:	_____	_____
Ocupación:	_____	_____

DATOS DEL HOGAR: Cantidad de personas en el hogar _____

¿Ambos padres viven en casa? ☐ Si ☐ No

¿Alguien en la casa fuma, usa drogas o alcohol? ☐ Si ☐ No

Idioma que se habla en el hogar: _____

¿Vive en una: ☐ Casa ☐ Apartamento ☐ Casa Móvil ☐ Refugio ☐ Sin Techo

Identificación del Paciente:

Firma:_____ Fecha:_____

Parentesco con el Niño: _____

Firma del Analista:_____ Fecha:_____

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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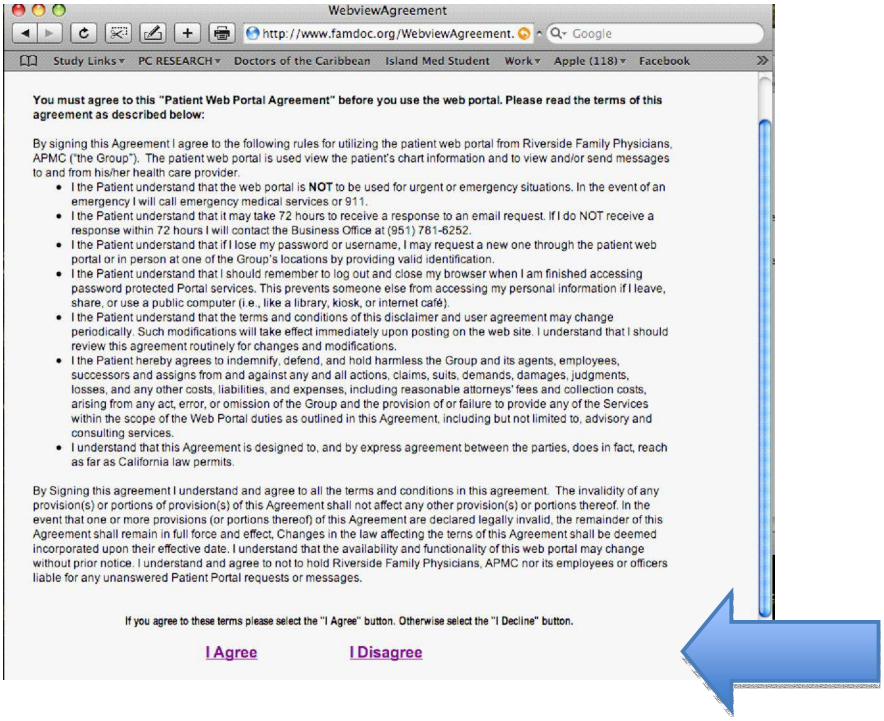
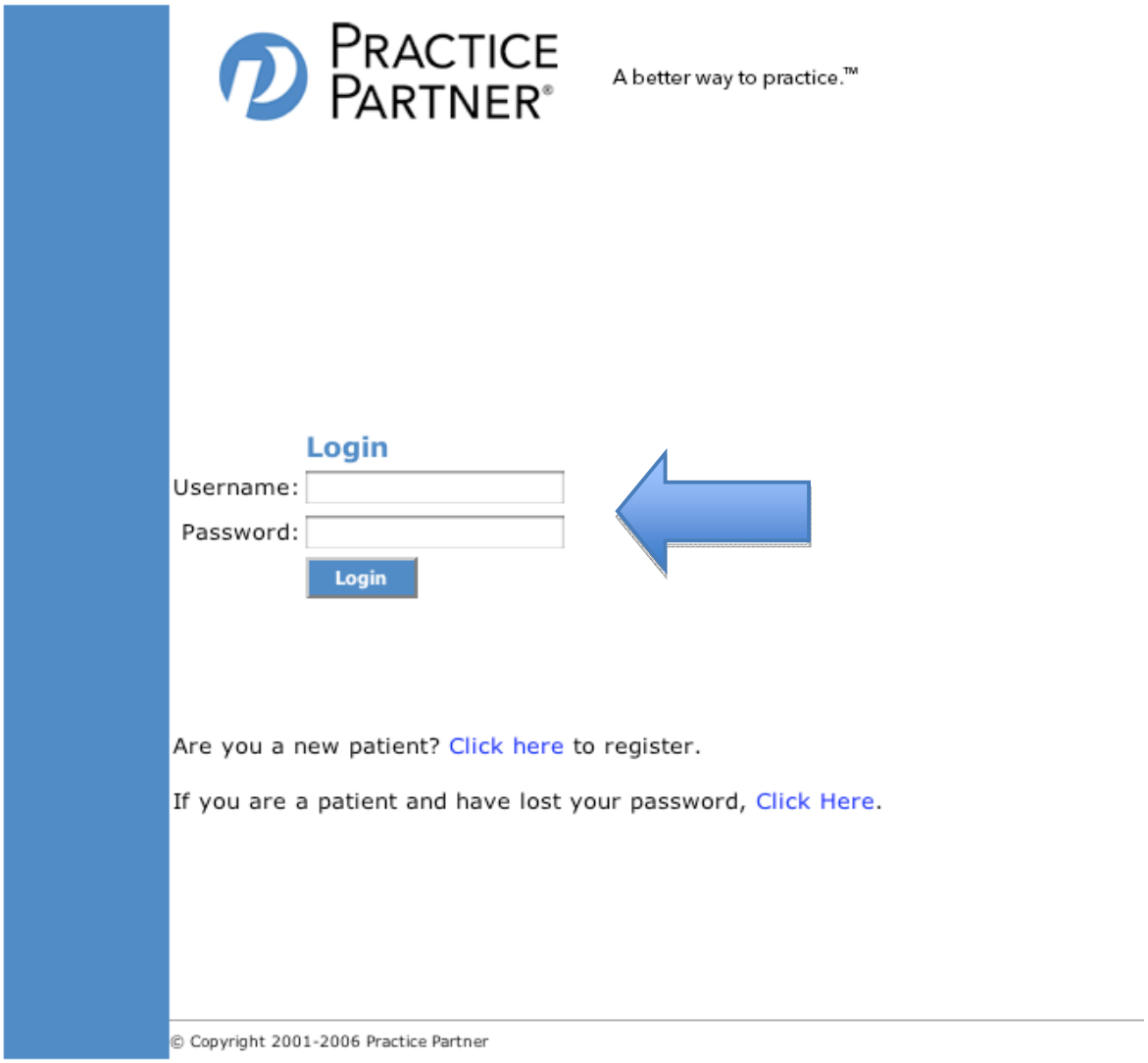
Webview Patient Portal Login Instructions

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.