# PATIENT INFORMATION FORM

FocilMed

**Full Name:** _____ **Date:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone #:** _____ **Alternate Phone #:** _____ **Cell ( ) Work ( )**

**Date of Birth:** _____ **SSN:** _____ **Male ( ) Female ( )**

**Driver's License Number:** _____ **Married Status:** Married ( ) Divorced ( ) Single ( ) Widowed ( )

**Spouse/Guardian:** _____ **Date of Birth:** _____

**Phone #:** _____ **SSN:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Are you Employed?** Yes ( ) No ( ) **Are you a student?** Yes ( ) No ( ) **Are you?** Full-Time ( ) Part-Time ( )

**Employer:** _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Do you have insurance?** Yes ( ) No ( ) **Company:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone #:** _____ **ID#:** _____ **Group #:** _____

**Policy Holder's Name:** _____ **Date of Birth:** _____ **Relationship to you:** _____

**Do you have Secondary insurance?** Yes ( ) No ( ) **Company:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone #:** _____ **ID#:** _____

**Policy Holder's Name:** _____ **Date of Birth:** _____ **Relationship to you:** _____

**Are your symptoms caused by an Accident?** Yes ( ) No ( ) **Work-Related Incident?** Yes ( ) No ( )

**If Yes, date of Accident/Incident?** _____ **Type of Accident?** Car ( ) Fall ( ) Work ( ) Other ( )

**Emergency Contact:** _____ **Relationship to you:** _____

**Home Phone #:** _____ **Work Phone #:** _____

**Who referred you to us?** _____ **Referring Physician:** _____

**Chief reason for doctor visit:** _____

| **Advanced Care Planing** | |
|---|---|
| Do you have a signed Living Will? | Yes☐ No☐ Don't Know☐ |
| Do you have an up-to-date Durable Power of Attorney for health care? | |
| Yes☐ No☐ Don't Know☐ | |

**If documents are presented, send for scanning to Advance Directives Registry.**

**EMAIL** _____

**X** _____

**Patient's Signature (or Legal Guardian)** **Date:**


## OUR FINANCIAL POLICY

Thank you for Choosing us as your health care provider. We are committed to your treatment and to all your healthcare needs, In order to better provide you with an exceptional service, we will need you to read and sign the following policies prior to your treatment. All of our patients must complete our patient information form prior to seeing our physician. We require that a copy of your ID or driver's license be provided.

**CASH PATIENTS**

Payment is full is due at the of service. There are NO EXCEPTIONS. We may ask that you pay the estimated charges prior to seeing the doctor. We accept Cash, Cashiers, Check, Visa, MasterCard, American Express, Discover, and Diners Club.

**MEDICAL INSURANCE**

At the beginning of each year, Medicare requires that patients pay deductible. For 2010 the deductible is $155.00. You will be required to pay up to $155 00 at the time of service. Also, note that Medicare pays only 80% of the allowed charges, and the remaining balance is the responsibility of the patient. The exception to this is if you have Medi-Medi (Medicare and Medi-Cal) or secondary insurance that pays the yearly deductible on co-insurance. All non-covered services are the patient's responsibility.

**MEDI-CAL INSURANCE**

We will bill your Medi-Cal as a courtesy, however, if you receive treatment for a non-covered service, it will be your financial obligation to pay in full at the time of service.

**PRO/ COMMERCIAL INSURANCE**

As a courtesy and part of our service, we will bill your health insurance. We require a copy of your valid medical insurance card. This does not relieve you of your financial obligation. If we do not receive payment from your insurance company within 90 days, the entire balance will be the responsibility of the patient or guarantor. If your insurance plan has a yearly deductible, full payment is due at the time of your visit. Co-pays and co-insurances are the responsibility of the patient and are to be paid at the time of your visit. Co-pays and co-insurance are the responsibility of the patient and are to be paid at the time of your visit. If we are not a contracted provider with your health insurance, any balance left after your insurance sends us the payment will be responsibility of the patient. NO EXCEPTIONS.

**INDUSTRIAL INJURIES**

Acceptance is on a case-by-case basis We will interview the party involved (patient) and determine whether or not we will accept the case. If you have an attorney, a signed lien is mandatory by both parties (attorney and patient). At no time is the patient relieved of any financial obligations. All unpaid balances are the responsibility of the patient or guarantor unless prior arrangements have been made with the billing department. All third-party claims require appropriate information to be provided by the patient. This includes auto insurance, liability insurance, or any other information pertaining to your injury.

I HAVE READ AN UNDERSTOOD THE FINANCIAL POLICY OF FOCILMED, INC. I AGREE TO ACCEPT THE TERMS AND CONDITIONS OF THE ABOVE FINANCIAL POLICY AND PROCEDURES.

**PRINT NAME:** _____

**SIGNATURE** _____ **DATE:** _____

# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1:** Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is a to whether any medical services rendered under this contract were unnecessary or unauthorized or more improperly, negligently, or incompletely rendered, will be determined by submission to attention as provided by California law provided for judicial review or arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accoupling the use of arbitration.

**Article 2**: All claims must be arbitrated: it his intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physicians, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

**Article 3:** Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within in my days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's a pro-rata share of the expenses and feed of the neutral arbitrator, together with the other expenses, of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or wrinkles fees, or other expenses incurred by a party for such party's own benefit.

Ether party shall have the absolute right to arbitrate separately the issue of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court potion, and upon such intervention and joinder, any existing court action against such additional person or unlikely shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers should apply to dispute within this arbitration agreement, including but not limited to Code of Civil Procedure Sections 340.5 and 567.7 and Civil Code Sections 3333 1 and 3333.2. Any party may bring before the arbitrator a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

**Article 4:** General Provisions: At claims based upon the same incident, transaction or related circumstance shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice, therefore, is received, the claim, if asserted in a civil action, would be barred by the applicable California status of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil provision relating to arbitration.

**Article 5:** Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and, if not revoked, will govern all medical services to the physician within 30 days of signature and if not revoked, will govern all medical services received by the patient.

Effective as of the date of the medical services.

If any provision of this arbitration agreement is held invalid or undetectable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**By:**

_____ _____

**Patient's Signature** **(Date)**

_____

**Print Patient's Name**

**By**

_____ _____

**(Date)**

**By:**

_____

**Patient's Representative's Signature** **(Date)**

_____

**Print Name and Relationship to Patient**

**A signed copy of this document is to be given to the Patient. Original is to be filled in Patient's medical records.**

# MEDI-CAL WAIVER

Si al tiempo de su consulta no tiene Medi-Cal, tiene que pagar su consulta No se le regresará su dinero y no mandaremos a cobrar Medi-Cal retroactivamente. Renuncio derecho de solicitar cobro a Medi-Cal retroactivamente.

If at the time of service, you do not have Medi-Cal, we expect payment in full. No refunds will be given, and we will not bill Medi-Cal retroactively, I walve the right to retroactively bill Medi-Cal.

`

**Firma/Signature**

**Fecha/Date**

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## FocilMed, Inc.

**PLEASE READ CAREFULLY**

This form authorized FocilMed, Inc, to use and disclosure your protected health information (PHI) for the purpose of healthcare operations, treatments, and payments activities.

Before signing, please read our Notice of Privacy Practices to gain a clear understanding of how we may use and disclose your PHI. We reserve the right to change our privacy practices and describes in our Notice of Privacy Practices. If we change your privacy practices, we will issue a revised Notice o Privacy Practices, which will contain the changes. Those Changes may apply to any of your protected health information that we maintain,

You will have the right to revoke this consent at any time by giving us a written notice of our revocation submitted to PRIVACY OFFICIAL. Please understand that revocation of this Consent will not affected any action we took in reliance on this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

**PATIENT INFORMATION**

**Name:** _____

**Address:** _____

**Phone:** _____

**DURATION**

**This authorization shall be effective immediately and remain in effect until** _____.

**PATIENT'S SIGNATURE**

- I, by signing this form, am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

- I, by signing this form, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

**Signed:** _____ **Date:** _____

If not signed by the patient, please indicate relationship:

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Beneficiary or personal representative of deceased patient

**Name of Representative:** _____

**You are certified to a copy of this consent after you sign it.**

**Include complete form in the patient's chart.**

FocilMed

(PATIENT NAME) _____ (DATE) _____

## ADULT HEALTH HISTORY FORM

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank You!

**Age** _____ **How would you rate your general health?** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Main reason for today's visit:** _____

**FAMILY HISTORY:** Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

| | | | |
|---|---|---|---|
| Alcoholism | _____ | High cholesterol | _____ |
| Cancer, specify type | _____ | High Blood Pressure | _____ |
| Heart disease | _____ | Stroke | _____ |
| Depression/suicide | _____ | Bleeding or clotting disorder | _____ |
| Genetic disorders | _____ | Asthma/COPD | _____ |
| Diabetes | _____ | Other: | _____ |

**REVIEW OF SYMPTOMS:** Please check any current symptoms you have.

**Eyes**
- ____ Change in vision

**Ears/Nose/Throat/Mouth**
- Difficulty hearing/ringing in ears
- Hay Fever/allergies/congestion
- Trouble swallowing

**Cardiovascular**
- ____ Chest pains/ discomfort
- ____ Palpitations
- ____ Short of breath with exertion
- ____

**Respiratory**
- ____ Cough/ wheeze
- ____ Coughing up Blood

**Gastrointestinal**
- Heartburn/reflux
- Blood or change in bowel movement
- Nausea/ Vomiting/ diarrhea
- Pain in abdomen

**Genitourinary**
- ____ Painful/bloody urination
- ____ Leaking Urine
- ____ Nausea/ vomiting/ diarrhea
- ____ Discharge: penis or vagina
- ____ Unusual vagina bleeding
- ____ Concern with sexual functions

**Musculoskeletal**
- ____ Muscle/ Joint Pain
- ____ Recent back-pain
- ____

**Neurological**
- ____ Headaches
- ____ Memory Toss
- ____ Fainting
- ____

**Psychiatric**
- Anxiety/stress
- Sleep Problem

**Blood/Lymphatic**
- ____ Unexplained lumps
- ____ Easy bruising/bleeding
- ____

**Endo**
- ____ Cold/heat intolerance
- ____ Increase thirst/appetite
- ____

Allergies or reactions to medicines: _____

**MEDICATIONS**: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

| **Medication** | **Dose (e.g., mg/ph)** | **How many times per day** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Staying Healthy Assessment

**Adult**

| Patient's Name (First & Last) | Date of Birth | ☐ Female ☐ Male | Today's Date |
|---|---|---|---|
| Person Completing Form (if Patient needs help) | ☐ Family Member ☐ Friend ☐ Other (Specify) | | Need help with form? ☐ Yes ☐ No |

***Please answer all the questions on this form as best you cam. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.***

**Need Interpreter?** ☐ Yes ☐ No

| | | | | | *Clinic Use Only:* |
|---|---|---|---|---|---|
| 1 | Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu? | Yes | No | Skip | Nutrition |
| 2 | Do you eat fruits and vegetables every day? | Yes | No | Skip | |
| 3 | Do you limit the amount of fried food or fast food that you eat? | Yes | No | Skip | |
| 4 | Are you easily to get enough healthy food? | Yes | No | Skip | |
| 5 | Do you drink a soda, juice drink, sports or energy drink most days of the week? | No | Yes | Skip | |
| 6 | Do you often eat too much or too little food? | No | Yes | Skip | |
| 7 | Are you concerned about your weight? | No | Yes | Skip | |
| 8 | Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day? | Yes | No | Skip | Physical Activity |
| 9 | Do you feel safe where you live? | Yes | No | Skip | Safety |
| 10 | Have you had any car accidents lately? | No | Yes | Skip | |
| 11 | Have you been hit, slapped, kicked, or physically hurt by someone in the last year? | No | Yes | Skip | |
| 12 | Do you always wear a seat belt when driving or riding in a car? | Yes | No | Skip | |
| 13 | Do you keep a gun in your house or place where you live? | No | Yes | Skip | |
| 14 | Do you brush and floss your teeth daily? | Yes | No | Skip | Dental Health |
| 15 | Do you often feel sad, hopeless, angry, or worried? | No | Yes | Skip | Mental Health |
| 16 | Do you often have trouble sleeping? | No | Yes | Skip | |
| 17 | Do you smoke or chew tobacco? | No | Yes | Skip | Alcohol, Tobacco, Drug Use |
| 18 | Do friends or family members smoke in your house or place where you live? | No | Yes | Skip | |

State of California- Health and Human Services Agency Department of Health Care Services

| | | | | | |
|---|---|---|---|---|---|
| 19 | In the past year, have you had:<br>☐ **(men)** 5 or more alcohol drinks in one day?<br>☐ **(women)** 4 or more alcohol drinks in one day? | No | Yes | Skip | Nutrition |
| 20 | Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? | No | Yes | Skip | |
| 21 | Do you think you or your partner could be pregnant? | No | Yes | Skip | |
| 22 | Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? | No | Yes | Skip | Sexual Issues |
| 23 | Have you or your partner(s) had sex without using birth control in the past year? | No | Yes | Skip | |
| 24 | Have you or your partner(s) had sex with other people in the past year? | No | Yes | Skip | |
| 25 | Have you or your partner(s) had sex without a condom in the past year? | No | Yes | Skip | |
| 26 | Have you ever been forced or pressured to have sex? | No | Yes | Skip | |
| 27 | Do you have other questions or concerns about your health? | No | Yes | Skip | Other Questions |

*If yes, please describe:*

| ***Clinic Use Only*** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered | Comments |
|---|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ | |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ | |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ | |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ | |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ | |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ | ☐ **Patient Declined the SHA** |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ | |

| | | |
|---|---|---|
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **SHA ANNUAL REVIEW** | | |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |
| **PCP's Signature:** | **Print Name:** | **Date:** |