Family Medical Clinic of Greater Sacramento
87 Scripps dr. suite #210 Sacramento,CA 95825
(916)5698585 *Fax (916)6400100

Patient Registration Form

Patient Last Name:	**First Name:**	**MI:**
Patient Social Security #:	**Date of Birth:**	
Address:		
City:	**State:**	**Zip:**
Home Phone: (_______)	**Work: (_______)**	
Known Allergies:	**Patient Gender:**	**Marital Status:**
Employer:		
Employer Address: **PPLUS Patients: Family Physician Name**		
	RESPONSIBLE PARTY	
If patient is under 18, or in Guardianship, list Legal guardian (or custodial parent) **Last Name:**	**First Name:**	**MI:**
Social Security #:	**Date of Birth:**	
Address:		
City:	**State:**	**Zip:**
Home Phone: (_______)	**Work: (_______)**	
Gender:	**Marital Status:**	
Employer:		
Employer Address:		

Patient over the age of 18 and a full time student? ___ ***If yes,*** **Where:** ______________________

SUBSCRIBER'S INFORMATION: (ATTACH COPY OF INSURANCE CARD – FRONT & BACK) (do not fill out if you are attaching a copy of your Insurance Card)

Primary Insurance: ______________________ **Policy #:** ______________________

Subscriber Name: ______________________ **Group #:** ______________________

Patient Relationship to Subscriber: ______________________

Employer: ______________________ **Soc Sec #:** ______________________ **Birth date:** ______________________

Secondary Insurance: ______________________ **Policy #:** ______________________

Subscriber Name: ______________________ **Group #:** ______________________

Patient Relationship to Subscriber: ______________________

Employer: ______________________ **Soc Sec #:** ______________________ **Birth date:** ______________________

There is not sufficient insurance information provided, we will assume the account is Self Pay.

Is a work related injury? ____________ **Date of Accident:** ____________ **Case #:** ____________

Emergency Contact Name: ______________________ **Phone #:** ______________________

Relationship to Patient: ______________________

In case of automobile accident please provide contact information:

____

Patient Signature: ______________________________ *Date:* ____________________

Family Medical Clinic of Greater Sacramento

Policies

MISSED APPOINTMENTS- If three (3) appointments are missed without contacting our office prior to the appointment time, we will no longer provide your medical care and discharge you from our practice.

LATE ARRIVAL- If you arrive 15 minutes past your scheduled time, your appointment will be rescheduled.

PAPERWORK- Allow 7-10 business days for completion of any paperwork. A charge of $10-15 per form is due **BEFORE** paperwork is completed. Let us know if forms are to be picked up or faxed.

REFILLS- Please allow 24-48 business hours for refills to be called to pharmacy. Check with the pharmacy first before calling the office back. Please have pharmacy send us the request.

INSURANCE PRIOR AUTHORIZATION- You are responsible for checking with your insurance company regarding scheduled procedures (MRI, CT can, referrals, etc.) Make sure if prior authorization is needed, it is obtained **BEFORE** the procedure is performed.

FOLLOW UP APPOINTMENTS- ALL lab and test results will be discussed at your follow up appointment. We will call you with any urgent results.

ANSWERING SERVICE- Our after hours answering service is provided for emergencies ONLY. Do not call with refill requests, lost medications, etc. If you have received a return call from the Doctor within 30 minutes, go to the emergency room.

NARCOTICS AND CONTROLLED SUBSTANCES- All narcotic medications or controlled substances are prescribed at the Doctor's discretion. You will be required to sign a narcotic contract and be subject to random drug screening.

FINANCIAL LIABILITY- Patient is responsible for all payment including co-payment deductable and covered fee if any procedure or test or visit is not covered by insurance.

NAME (print) ______________________________

NAME (sign) ______________________________ DATE _______________

WITNESS ________________________________ DATE _______________

MEDICATION PROTOCOL

A medication protocol for all patients has been implanted. The specific protocol is outlined below. All patients are requested to acknowledge that they read the protocol and agree to abide by its provision.

All clinic personnel have also reviewed the protocol and will implement and abide by it. Unless the physician personally consents to a request for a deviation from the protocol, it will be followed explicitly.

1. All medication requests, if approved, will be filled within 48 hours, usually sooner, after the request has been received either from the pharmacy or the patient. It is important that patients monitor the amount of medication remaining in their current prescription in order to avoid running out of a medicine before a refill can be called in.
2. All medications are to be taken as prescribed. If there are many questions or problems with the medications, they should be directed to the medical assistant. The medical assistant will notify the physician as necessary. If there is an urgent or emergency matter, the physician will be notified and the patient will be directed to an Urgent Care Facility or Emergency Room as indicated. A physician will always be available for questions or problems.
3. If a request for medication refill is made, it will be denied if requested prior to the time the medication should run out.
4. Without written authorization from the doctor, a patient who has not been examined within the preceding 90 days and is requesting refills of medication may not have the medication refilled.
5. If a request for medication refill has been denied, the patient will be notified as soon as possible and will be given the reasons why the medication will not be refilled. The patient may be directed to schedule an appointment for examination inn order to ensure that the medication requested is, in fact still appropriate for their condition.
6. In connection with certain medications, patients may be requested to have a blood test every three to six months to allow continued usage of these medications.
7. **Medication refill request will be taken and processed during normal office hours only.**
   Medication refills will **NOT** be given at **NIGHT**, on **WEEKENDS**, and/or on **HOLIDAYS**.
8. Stronger narcotic medications, including those requiring additional paperwork, such as triplicate forms or Department of Public Safety/Drug Enforcement Agency Stickers, are not used. The doctors do not have triplicate prescription forms or stickers readily available.
9. **NO** narcotic pain medications, tablet or injection, are kept on the premises.
10. Narcotic pain medications are used for acute pain, such as that associated with recent injury or surgery, and are not used for the management of long-term or chronic pain. A referral to on of several pain management groups is available for patients in need of long-term management.

After reviewing the protocol, I understand and agree to its provisions.

_______________________________ Date:____________________

Patient/ Guardian Signature

____

Print Patient/ Guardian Name

Family Medical Clinic of Greater Sacramento
HIPAA NOTICE OF PRIVACY PRACTICE

I am aware of the HIPAA Notice of Privacy practices for Family Medical Clinic of Greater Sacramento office and the copies of the notice are available for me to take upon request. I Hereby authorize ___________________________ to use and disclose my protected health information ("Health information") as defined by federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person entity authorized by this document to receive my Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.
Any and all of my health information in possession of __________________ may be disclosed to any entity _______________________ determines necessary to receive this information. This includes medical records, claims/billing information, mental health records and drug/alcohol abuse records if necessitated by medical or legal requests.

I understand that my health care will not be affected if I do not sign this form.

I understand that this authorization will expire on my written request to cancel this authorization or upon my leaving the practice.

I also understand that I may revoke this authorization at any time by notifying________________, in writing. I understand that my revocation of this authorization will not affect any actions by____________, on this authorization prior to the time it received my revocation.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONS

I give my authorization to release medical surgical information to the following designated representatives:

Patient initials:
___Parent or guardian of minor patient (to the extent minor could not have consented to the care):
___ Guardian or conservator of an incompetent patient

___ Beneficiary or personal representative of deceased patient:
___ May not be given to anyone other than myself

I hereby authorize medical information relayed to me via:

___ Home Phone #: ____
___Cell Phone #: ____

Patient Name:____

Patient Signature: _____________________________Date: ________________________

Family Medical Clinic of Greater Sacramento

FINANCIAL POLICY

We are committed to providing you with the best possible care and treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Financial Policy, which we require you to read and sign prior to your visit.

PAYMENT IS DUE AT THE TIME OF YOUR SERVICE

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER CARD.

Regarding Insurance:

Our insurance policy is a contract between you and your insurance company. We are not a party to that company, along with guidelines of our contract. However, we require that **ALL CO-PAYS OR DEDUCTIBLES BE PAYED** at the time of the services. If we do not participate with your insurance company, we ask that payment be made at the time of the services rendered and your insurance company will reimburse to you any amount due.

You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information, you will be required to pay for the services rendered to you that day. We **DO NOT** accept third party insurance or auto accident claims.

Minor Patients:

The parent/guardian who presents the child for medical treatment is the responsible party. Of payment for services is to be by someone else, the parent/guardian with the child should pay and have the other party reimburse them. Any legal agreement between the parents has nothing to do with the practice.

Other Fees:

We charge a $ 25.00 fee for all return checks.
After reviewing the Financial Policy, I understand and agree to its provisions.

There will be a $2.00 charge for credit card processing.

______________________________ _______________
Parent/Guardian Signature Date

Print Name: ______________________________

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

______ I acknowledge that I was provided a copy of the Notice of Privacy Practices and that

_____I have read (or had the opportunity to read if I chose) and understood the Notice.

_____I acknowledge I was provided a receipt of Notice of Privacy Practice

____ ____________________
Patient Name (please print) Date

____
Parent or Authorized Representative (if applicable)

____
Signature

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I acknowledge that I am responsible for following my physician's recommendations and to do what is necessary to control and treat my condition.

I understand that the sole responsibility of my health and well being is in my hands in view of the above and that I cannot reasonably hold my physician responsible if I do not adhere to his recommendations and/or not take medications as I am instructed to do so.

____
Patient Signature

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Family Medical Clinic of Greater Sacramento to use discloses protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). The Notice of Privacy Practices provided by Family Medical Clinic of Greater Sacramento describes such uses as disclosures more completely.

_______(initial) I acknowledge that I have been provided a copy of the Notice of Private Practices and that I have had the opportunity to read, if I so choose, and understand the Notice.

I have the right to review the copy of Notice of Private Practices prior to signing this consent. Family Medical Clinic of Greater Sacramento reserves the right to revise its Notice of Privacy Practices at any time. A revise Notice of Privacy Practices may be obtained by forwarding a written request to Family Medical Clinic of Greater Sacramento

With this consent, Family Medical Clinic of Greater Sacramento. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Family Medical Clinic of Greater Sacramento may mail to my home or other alternative location any items that assist in carrying out TOP, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Family Medical Clinic of Greater Sacramento may e-mail to my home or other alternative location any items that assist in carrying out TOP, such as appointment reminder cards and patient statements. I have the right to request that Family Medical Clinic of Greater Sacramento restrict how it uses or discloses my PHI to carry out TOP. The practice is not required to agree to my request restrictions, but if does, it is bound by this agreement.

By signing this form, I am consenting to allow Family Medical Clinic of Greater Sacramento to use and disclose my PHI to carry out my TOP.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Family Medical Clinic of Greater Sacramento may decline to provide treatment to me.

Signed by: ____

Signature of Patient or Legal Guardian | Date | Relationship to Patient

____

Print Patient's Name | Print Name of Legal Guardian (if needed)