Garrison Family Medical Group, Inc.

Nurturing mind, body and spirit

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Patient Last Name First Name MI			☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status ☐Single ☐Mar ☐Div ☐Sep ☐Wid	
Home Address POB/Apt#		City		State	Zip
Social Security Number - -	Drivers License	Birth Date / /	Age	Sex ☐Male ☐Female	
Email Address	Day Phone ( )		Cell Phone ( )		
Ethnicity	Race		Spoken Language		
Employer	Employer Address		Employer Phone		

INSURANCE INFORMATION *PLEASE GIVE YOUR INSURANCE CARD/ID CARD TO THE RECEPTIONIST*			
Primary Insurance Name		Type of Insurance ☐PPO ☐PPS ☐Medicare ☐Managed Care (HMO) ☐Other	
Address (if different)		Home Phone (if different) ( )	
Subscriber's Name		Social Security Number - -	Birth Date / /
Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other	CoPay Amount $	Group No.	Policy No.

EMERGENCY CONTACT			
Name of local individual (*Not living at the same address*)	Relationship	Home Phone ( )	Work Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician (*Please initial*) _____. I understand that I am financially responsible for any balance. I understand any Laboratory charges are separate and I will be billed by an outside lab. (*Please initial*) _____. I also authorize Garrison Family Medical Group Inc. or insurance company to release any information required to process my claims (*Please initial*) _____.

*Parent/Guardian Signature*_____ *Date*_____

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OUR FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your heath care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment. Therefore, if you have any questions or concerns about our payment policy, our staff will be happy to address them. We ask that all patients read and sign our financial policy as well as complete our Patient Registration Form prior to seeing the physcian. Payment for services is due at the time they are rendered. We accept cash, check and credit cards (There is a $50.00 addition charge for returned checks.)

For those who have medical insurance:

1. **As a courtesy we will be happy to process your insurance claim for you. However, all charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts.**

2. **We accept assignment of insurance benefits, which means your insurance company sends payment for our services directly to our office.**

3. **Deductibles and co-payments are due at the time of service.**

4. **If your insurance company does not pay within a reasonable amount of time, and after we have made numerous attempts to collect, we will ask that you contact your insurance carrier and inquire as to why the claim has not been paid.**

5. **You will be charged a $50.00 fee if you fail to arrive to your appointment or cancel within 24 hours of your appointment time.**

We understand that temporary financial problems may affect timely payment on your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account. Again, thank you for choosing us as your health care provider. Please sign and date below.

_____ _____

Patient Signature **Date**

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EMERGENCY CONTACT INFORMATION

I,_____hereby give my permission for Garrison Family Medical

Group/A.V. Urgent Care to contact_____in case of an emergency.

Contact Information:

Address:_____

Home phone:_____

Cell phone:_____

Work phone:_____

Relationship to patient:

- ☐ **Spouse**
- ☐ **Guardian**
- ☐ **Other_____**

PLEASE SIGN AND DATE BELOW:

_____ _____

PATIENT SIGNATURE **DATE**

_____

PRINT PATIENT NAME

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PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individual the right to request a restriction on uses and discloures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a commuication of PHI is made by alternative means, such as correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

- ☐ **Home phone:**
  - **Okay to leave message with detailed information**
  - **Leave message with call back number ONLY**

- ☐ **Written communication:**
  - **Okay to mail to my home address**
  - **Okay to mail to my work/office address**
  - **Okay to fax to this number:_____**

- ☐ **Work telephone:**
  - **Okay to leave message with detailed information**
  - **Leave message with call back number ONLY**

- ☐ **Other:_____**

I have had an opportunity to receive and review the Notice of Privacy Practices of Garrison Family Medical Group, Inc. Please sign and date below.

_____ _____

PATIENT SIGNATURE **DATE**

_____

PRINT PATIENT NAME

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PATIENT INFORMATION RELEASE

I (patient name)_____authorize/do not authorize release of my medical information at any time to (person information being release to)_____

Relationship:

- ☐ **Spouse**
- ☐ **Guardian**
- ☐ **Other_____**

Information to be released:

- ☐ **All**
- ☐ **Test results**
- ☐ **Health status**
- ☐ **Other_____**

PLEASE SIGN AND DATE BELOW:

_____ _____

PATIENT SIGNATURE **DATE**

_____

PRINT PATIENT NAME

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AUTHORIZATION TO TREAT MINOR

I,_____hereby give my permission for Garrison Family Medical

Group/A.V. Urgent Care to treat my minor child_____without my presence.

Check all that apply:

- ☐ **Emergency only**
- ☐ **Routine appointments only**
- ☐ **Routine and/or emergency**
- ☐ **Other (please specify) _____**

Signature of parent or legal guardian:_____
Date:_____
Date of birth of minor child:_____
Known allergies:_____

This authorization will remain in effect until (specify a date or until the child is 18 years old):_____

GARRISON FAMILY MEDICAL GROUP – PATIENT HISTORY

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE_____/___/_____ DATE OF LAST PHYSICAL EXAM____/___/_____

LAST NAME_____ FIRST NAME_____

SOCIAL SECURITY NO. _____-____-_____DATE OF BIRTH_____/____/_____

CHIEF **MEDICAL** COMPLAINT:

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

History of Present Illness

Please answer the following questions:

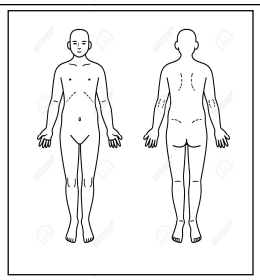
Location of the problem

Abdomen Back Leg

Other_____

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1 2 3 4 5 6 7 8 9 10



When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing up Lying on my side

Is anything else occurring at the same time?

YES NO If yes, please explain.

Nausea Rash Headaches

Other:_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Past Medical, Family & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

Please indicate if living or deceased, cause of death, and age.

Mother_____

_____

Father_____

_____

Siblings_____

Grandparents_____

_____

Other_____

_____

_____

List any personal past illness

_____

_____

_____

_____

Surgical history Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you on a special diet? □ Yes □ No No (If yes, please explain)

_____

_____

Do you have allergies? (Medication/Food, indicate reaction)

□ None_____

Tobacco use? □ Yes □ No

If yes, how much?_____

Alcohol use? □ Yes □ No

If yes, how much?_____

Do you exercise regularly? □ Yes □ No

If yes, how much?_____

Caffeine? □ Yes □ No

If yes, how much?_____

Current Occupation:

_____

Marital status: (other)_____

Married, Single, Divorced, Domestic Partner

Are you currently taking any medication? (Please list name/dose/frequency if known)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Immunizations: (Please list approximate date of last, or provide copy of immunization record) Tetanus:_____ Pneumonia:_____

Influenza:_____Zoster (shingles):_____HPV:_____Have you tested or vaccinated for Hepatitis A, B or C?_____

Last TB screening:_____Positive:_____Negative:_____Chest X-ray done? (If positive)_____

Review of systems

Please √ for symptoms you have experienced. Circle for systems you are experiencing TODAY.

General/Constitutional
□ Change in appetite
□ Weight gain
□ Weight loss
□ Pain
□ Difficulty sleeping
□ Sleep problems
□ Night sweats
□ Fever
□ Chills
□ Dizziness

Eyes
□ Eye discharge
□ Eye dryness
□ Excessive tearing
□ Eye irritation/itching
□ Pain
□ Red eyes
□ Blurred vision
□ Double vision
□ Flashing lights
□ Seeing spots

ENMT
□ Change in hearing
□ Ear discharge
□ Ear pain
□ Ringing in the ears
□ Nasal discharge
□ Nasal obstruction
□ Nose bleeds
□ Sinus pain
□ Sinus/nasal congestion
□ Mouth problems
□ Bleeding gums
□ Denture problems
□ Dry mouth
□ Mouth sores
□ Tongue pain
□ Difficulty swallowing
□ Sore throat
□ Change in voice
□ Hoarseness

Cardiovascular
□ Chest pain
□ Chest pressure/discomfort
□ Heart trouble
□ Heart murmur
□ Lightheadedness
□ Palpitations
□ Leg cramps
□ Swelling

Respiratory
□ Difficulty breathing
□ Wheezing
□ Cough

Gastrointestinal
□ Abdominal pain
□ Nausea
□ Vomiting
□ Heartburn
□ Constipation
□ Diarrhea

Genitourinary
□ Losing control of urine
□ Urinary urgency
□ Night-time urination
□ Frequent urinating
□ Burning or pain urinating
□ Difficulty urinating
□ Reduced stream
□ Dribbling

Musculoskeletal
□ Joint pain
□ Muscle pain
□ Stiffness
□ Neck pain
□ Back pain

Integumentary
□ Bruising
□ Itching
□ Mole changes
□ Rash

Hematologic/Lymphatic
□ Easy bleeding or bruising
□ Anemia
□ Swollen glands

Allergic/Immunologic
□ Immunodeficiency
□ Hay Fever History

Neurological
□ Headaches
□ Migraines
□ Seizures
□ Fainting
□ Ringing in the ears
□ Short term memory problems
□ Long term memory problems
□ Confusion/Disorientation
□ Delusions
□ Change in personality
□ Speech changes
□ Facial weakness/numbness
□ Weakness/numbness in arm
□ Weakness/numbness in leg
□ Numbness/tingling
□ Muscle weakness
□ Loss of limb use
□ Tremors
□ Balance problems
□ Change in gait
□ Losing control of gait or bowel

Psychiatric
□ Anxiety
□ Nervousness
□ Depression
□ Sadness
□ Hallucinations
□ Suicidal thoughts
□ Stress
□ History of Bipolar or Schizophrenia

Endocrine
□ Excessive appetite
□ Excessive thirst
□ Excessive urination
□ Heat intolerance
□ Cold intolerance
□ Hair loss

Other:_____

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TO: Our Patients

RE: Your Scheduled Physical Examination or Pre-Op

If you are seeing one of the Doctor's, Nurse Practioner or Physician Assistant today for a complete physical examination, immunization, or pre-op, this office needs to make you aware of the submission of your claim to your insurance company for reimbursement.

If this is a Well Adult Physical and you have no symptoms or no physical anomalies discovered during your examination, your visit will be submitted as such. Please confirm that your insurance company covers this routine care.

If this is a Well Adult Physical but you indeed have medical problems, unless you notify us to bill it to your insurance company as your "Yearly Physical" we will submit the claim with medical diagnosis.

If this is a pre-op, you could be held responsible to pay this bill. Some insurance companies won't cover the required preoperative testing at a physician's office but will cover it if you have those tests done at the facility where your procedure is being performed. It is your responsibility to find out if your insurance company will cover your pre-op being done here. If your insurance company won't approve these charges then you will be held responsible to the pay the bill.

We are also finding that many insurance companies are challenging the lab work that might accompany your physical exam. As an example: When the lab order is written, we might not know that your cholesterol is elevated (thus allowing us to note the diagnosis of Hypercholesterolemia) and the request will leave this office with the notation: Routine Physical Exam.

If you have any questions about your scheduled appointment today or in the future, please speak to a receptionist or the office manager.

Your signature on this notification advises for the future reference that you acknowledge this information we have given you regarding the submission of your claim for services rendered today. Thank you.

PATIENT SIGNATURE **DATE**

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you get access to the information. Please review carefully.

Garrison Family Medical Group (GFMG) uses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Garrison Family Medical Group.

HOW GFMG MAY USE OR DISCLOSE YOUR HEALTH INFORMATION:

FOR TREATMENT: GFMG may use your health information to provide you with medical treatment or services. For example, information obtained by a health provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record action taken by them in the course of your treatment and note how you respond to the actions.

FOR PAYMENT: GFMG may use and disclose your health information to others for the purpose of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of the treatment.

FOR HEALTH CARE OPERATIONS: GFMG may use and disclose your health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality management personnel, and others in order to:

- **Evaluate the performance of our staff.**
- **Assess the quality of care and outcomes in your case and similar cases.**
- **Learn how to improve our facilities and services.**
- **Determine how to continually improve the quality and effectiveness of the heath care we provide.**

APPOINTMENTS: GMFG may use your information to provide appointment reminders or information about treatment alternatives or other health related services that may be of interest to you.

REQUIRED BY LAW: GFMG may use your information as required by law. For example, GFMG may disclose information for the following purposes:

- **For judicial and administrative proceedings pursuant to legal authority.**
- **To report information related to victims of abuse, neglect, or domestic violence.**
- **To assist law enforcement officials in their law enforcement duties.**

PUBLIC HEALTH: Your health information may be used to disclose for public health activities such as assisting public authorities to prevent or control disease, injury, disability, or other health oversight activities.

DECEDENTS: Health information may be used or disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

ORGAN/TISSUE DONATIONS: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

RESEARCH: GFMG may use your health information for research purposes when an institutional review board/privacy board that has reviewed and approved the research.

HEALTH AND SAFETY: Our health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

GOVERNMENT FUNCTIONS: Specialized government functions such as the protection of public officials or reporting to various branches of the armed services that may require the disclosure of your health information.

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THE PATIENT'S RIGHTS AND RESPONSIBILITIES

1. **Patients are given consideration and respectful care.**
2. **Patients are provided appropriate privacy regarding medical records and during interviews, examinations, treatment and consultation. Medical information will not be released without patients' written consent.**
3. **Patients are given an opportuntity to participate actively in any decision regaring medical care to the extent permitted by the law; This includes the right to refuse treatment.**
4. **Patients are provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis; When it is provided to a person designated by the patient or to a legally authorized person.**
5. **Patients should have knowledge of the name of the physician primarily responsible for care and the names and roles of any other physician involved in their care.**
6. **Patients, prior to treatment, are informed of their financial responsibility and are provided with a receipt.**
7. **Patients should have reasonable continuity of care and know in advance the time and location of appointment as well as the identity of persons providing care.**
8. **Patients have the ability to have their complaints addressed and receive an appropriate response.**
9. **Facility should provide information to patients and staff concerning:**
    - **Services available at the facility.**
    - **Provision for after-hour and emergency care.**
    - **Fees for services and payment policies.**
    - **Methods for expressing grievances and suggestions to the facility.**

PATIENTS RESPONSIBILITIES

1. **Patients are to participate in and follow agreed upon plan of care.**
2. **Patients are to fully participate in decisions involving their own health care.**
3. **Patients are to cooperate with the physician and ask questions if you do not understand instructions or information.**
4. **Patients are to provide physician with a complete and accurate history about illnesses, hospitaliztions, medications and other matters related to your health.**
5. **Patients are to notify the facility if there is any problem or dissatisfaction with care or services.**
6. **Patients are to treat personnel with respect, consideration and dignity.**
7. **Patients are to give 24 hour notice when cancelling an appointment.**

WORKERS COMPENSATION: **Your health information may be used or disclosed in order to comply with laws and regulations related to workers compensation.**

YOUR HEALTH INFORMATION RIGHTS:

YOU HAVE THE RIGHT TO:

- **Request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R.164.522; however, GFMG is not required to agree to a requested restriction.**
- **Obtain a paper copy of the notice of information practiced upon request.**
- **Inspect and obtain a copy of your health record as provided for in 45 C.F.R. 164.524.**
- **Amend your health record as provided for in 45 C.F.R 164.526.**
- **Request in writing that communications of your health information by alternative means or at alternate locations.**
- **Revoke your authorization to use or disclose health information except to the extent that action has already been taken.**
- **Receive an accounting of disclosures made of your health information as provided by 45 C.F.R.**

COMPLAINTS

You may complain to GFMG and to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

OBLIGATIONS OF GFMG

GFMG is required to:

- **Maintain the privacy of protected health information.**
- **Provide you with this notice of its legal duties and privacy practices with respect to your health information.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.**
- **Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.**
- **Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.**

GFMG reserves the right to change its information practices and to make new provisions effective for all protected health information it maintains. Revised notices will be made available to you at your next appointment after the change.

CONTACT INFORMATION

If you have any questions or complaints please contact:

Garrison Family Medical Group
41210 11th St. W Suite A, B, C, D and E
Palmdale, CA 93551
Office # (661) 947-7100
Fax # (661) 947-5151