PEACHWOOD MEDICAL GROUP

DATE:____________________

PCP:____________________ **ACCOUNT:**____________________

PATIENT REGISTRATION FORM

*** PATIENT**			
NAME		SSN	DOB
ADDRESS		SEX	PHONE
CITY	ST	ZIP	CELL
MARITAL STATUS	EMPLOYER/SCHOOL		EMP PHONE

*** RESPONSIBLE FOR PATIENT (ONLY IF PATIENT IS UNDER 18 YRS OLD)**			
NAME		SSN	DOB
ADDRESS		SEX	PHONE
CITY	ST	ZIP	MARITAL STATUS
RELATION TO PATIENT		EMPLOYER	

*** INSURANCE INFORMATION**	
NAME OF INSURANCE	**ID#**
GROUP#	**EFFECTIVE DATE**

*** SUBCRIBER/POLICY HOLDER (WHO IS THE EMPLOYEE?)**	
NAME	**DATE OF BIRTH**
SS#	**RELATION TO PATIENT**

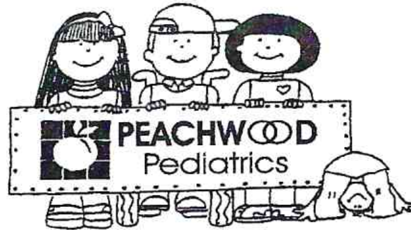
*** EMERGENCY CONTACT/GUARDIAN**			
NAME			PHONE
ADDRESS			RELATION TO PATIENT
CITY	ST	ZIP	GUARDIAN NAME

This office will bill all HMO and PPO contracted payers- copayments and/or deductibles must be paid at time of visit.

I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to the physicians or suppliers of services rendered.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. I understand that I am financially responsible within a 30-day period for all charges whether or not paid by said insurance. I hereby authorize said insurance to release information necessary to secure payment.

Signed:____________________________ Date:________________________



Peachwood Medical Group, a part of Community Medical Providers, a member of Community Foundation Medical Group, a part of Sante' Health Foundation

General Consent To Treatment and Right To Refuse Treatment

General Consent to Treatment: By signing below, I, (or my authorized representative on my behalf) authorize Peachwood Medical Group Provider's and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment: In giving my general consent to treatment; I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

While I understand that I am required to sign this consent, I may revoke this consent at any time in writing to Peachwood Medical Group.

Date:______________________________

Patient's Name:____

Patient/Parent/Guardian Signature:______________________________________

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that we seek your acknowledgment of receipt of the Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of November 1, 2011 and understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

I hereby provide my consent for Peachwood Medical Group to obtain my Rx history using the Sure Scripts network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that Sure Scripts has certified that Rx History Capture follows strict security protocols to align HIPAA requirements and respect patient privacy.

______________________________	______________________
Printed Name	Date

____

Signature

Part of: COMMUNITY MEDICAL PROVIDERS

A member of Community Foundation Medical Group & part of Santé Health Foundation

Peachwood Medical Group

Cancellation/ No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty-five dollar ($35.00) fee; this will not be covered by your insurance company.

______________________ _______________________ ____/____/____

Patients Name (Please Print) Date

____

Signature Patient/Guardian

PATIENT PROVIDER ESTABLISHED RELATIONSHIP

It is important to your health and well-being that you visit your physician on an annual basis. If you do not have a visit with your physician for more than three years you will be considered inactive. It will be at the discretion of the physician if he/she wishes to re-establish your care.

I have read and understand the above policy.

______________________________________ ____________________

Patient/Parent/Guardian Signature Date

PEACHWOOD MEDICAL GROUP

Financial Policy

Payment in full is required at the time of service for all services provided in the physician's office, Urgent Care or Lab/X-ray unless you fall into one of the categories listed below. All patient co-payments are due and payable at the time of service. If you are unable to make your co-payment at the time of service, and your appointment is not of an emergency nature, we reserve the right to reschedule your appointment until such time as you are able to make your co-payment.

Insurance Billing: As a courtesy, this facility will bill your insurance if you belong to any of the HMO's and PPO's we are currently contracted with. It is your responsibility to make sure that we have current copies of your card (s); any completed claim forms necessary and correct billing addresses. Please note that you, as the patient, are responsible for knowing the scope of your health coverage benefits, i.e. (co-pays, deductible, co-insurance and overall plan coverage).

Medicare, Secondary Insurance & Medi-Cal: Peachwood Medical Group accepts assignment for Medicare. We will then bill secondary insurance, providing we have complete and current secondary billing information. For our existing patients proof of eligibility is required for each visit. Acceptance of Medi-Cal as insurance is at the discretion of each physician.

Obstetrical Patients: Individual financial arrangements will be made with all obstetrical patients in order to determine maternity coverage and payment requirements.

Worker's Compensation: This facility will bill for the first visit of worker's compensation injuries in **Urgent Care only**. The patient must present with a signed *Authorization for Treatment* from their employer at the first visit. The patient is also responsible to provide this facility with any/all necessary billing information at that first visit. Once the worker's compensation carrier has released a patient from its financial responsibility or benefits have been denied, the patient is then responsible for payment in full of services rendered.

Personal Injury or MVA: As a courtesy, this facility will bill the patient's MVA Insurance, if all the necessary information is provided at the first visit. This includes Third Party Liability for Peachwood patients only. To avoid any possible litigation, this facility will not bill any third party liability for non-Peachwood patients or accept liens for these types of injuries on any patient. A copy of the encounter form will be provided upon request for the patient to submit for reimbursement directly. Patient will be responsible for payment in full should the claim be denied by insurance or payment is delayed more than 60 days.

Monthly Statements: Statements are generated at this facility on a monthly basis via "cycle" billing. They are a request for payment of what is currently at "patient due" responsibility. All patient balances are due and payable upon receipt of the statement, unless special payment arrangements have been made with the billing department in advance. All statements will be sent by Community Medical Providers for services rendered at Peachwood Medical Group.

***Peachwood Medical Group is a part of Community Medical Providers, a member of Community Foundation Medical Group and a part of Sante' Health Foundation.**

I have read the above policy and agree to comply with its provisions.

____________________________________ __________________

Signature of Patient and/or Responsible Party Date

PEACHWOOD MEDICAL GROUP
275 W. Herndon Ave.
Clovis, Ca. 93612

THIRD PARTY CONSENT AUTHORIZATION FOR MEDICAL TREATMENT

Child's Name: ______________________________________ DOB: ______________

I hereby authorize the following adults:

____ Relationship to minor: _____________

____ Relationship to minor: _____________

____ Relationship to minor: _____________

____ Relationship to minor: _____________

To seek, obtain and consent to routine and emergency medical care and treatment, procedures and vaccinations for my child listed above as deemed necessary by a licensed medical or healthcare professional. This authorization is for the time period when my child is in the care of the person / people listed above. I may revoke or edit this consent at any time.

This authorization is under the Health Insurance Portability and Accountability Act of 1996.

Signed: ____ Date: _______________

Print Name: ______________________________ Relationship to Minor: _____________

( ) This authorization is to be in effect from ____________ to ______________.

( ) This authorization is to remain in effect until revoked by the above signed.

PEACHWOOD MEDICAL GROUP
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide authorization.

Copies of the signed authorization will be considered as valid as the original

I hereby authorize ______________________________

NAME OF DISCLOSING PARTY

____

ADDRESS

____

CITY STATE ZIP PHONE FAX

To disclose to **Amy Evans, MD / Dianne Hubbard, MD / Marty Martin, MD / Brad Sumrell, MD / Will van Beever, DO**

NAME OF RECEIVING PARTY

275 W Herndon Ave

ADDRESS

Clovis	**CA**	**93612**	**(559) 324-6202**	**(559) 324-6282**
CITY	STATE	ZIP	PHONE	FAX

Records and information pertaining to:

____

NAME OF PATIENT (LIST OTHER NAMES USED) DATE OF BIRTH

____

ADDRESS CITY STATE ZIP PHONE

DURATION: This authorization shall become effective immediately and shall remain in effect until__________ or for one year from the date of signature

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent the Requestor or others have acted in reliance upon the authorization

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law

RECORDS: All medical information_________(initial). A separate authorization is required for HIV disclosure or psychotherapy notes.

Specify the records to be disclosed: ______________________________

____

The requester may use the health information authorized on this form for the following purposes only: ______________________________

____

I understand that I have the right to receive a copy of this authorization.

____

Signature Patient/Legal Representative/Guardian Relationship to patient Date

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY　　DATE COMPLETED

BIRTH DATE　　AGE　　M　F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. ______

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ■ Don't know birth history

Birth weight ______ Was the baby born at term? ______ OR ______ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain ______

Was a NICU stay required? ☐ Yes ☐ No Explain ______

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No　Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What ______ When ______

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? ______

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain ______

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ______

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ______

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ______

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain ______

Biological Family History DK = don't know

Have any family members had the following?

Condition	Yes	No	DK	Who	Comments
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Asthma	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Anemia	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Dental decay	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

(Biological Family History continued on back side.

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain ______
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ______
HIV	☐ Yes	☐ No	☐ DK	Explain ______
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ______
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ______
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ______
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ______
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ______
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ______
Cancer	☐ Yes	☐ No	☐ DK	Explain ______
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ______
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ______
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ______
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ______
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ______
Obesity	☐ Yes	☐ No	☐ DK	Explain ______
Diabetes	☐ Yes	☐ No	☐ DK	Explain ______
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ______
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ______
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ______
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ______
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ______
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ______
Dental decay	☐ Yes	☐ No	☐ DK	Explain ______
History of family violence	☐ Yes	☐ No	☐ DK	Explain ______
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ______
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ______
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain ______

Has had first period ☐ Yes ☐ No Age of first period ______

Any other significant problem ______

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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