

Dr. Miss Mr. Mrs. Ms. Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____

City _____ State _____ Zip _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address: _____

Date of Birth MM ____ /DD ____ /YYYY ____ Sex F-Female M-Male Transgender

Race American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander Black or African American White Declined

Ethnicity Hispanic or Latino Not Hispanic or Latino Declined

Language English Spanish Indian Japanese Chinese Korean French German Russian Other _____

Marital Status Married Single Divorced Widowed Legally Separated Partner

Social Security Number _____ - _____ - _____ Employer Name _____

Employment Status 1- Full-Time 2- Part-Time 3- Not Employed 4-Self-Employed 5-Retired 6-Active Military

Student Status F-Full-Time Student P-Part-Time Student N-Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? Yes No

Emergency Contact Relationship to Patient _____ Guardian

Address Line 1 _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party Another Patient Guarantor Self **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____ /DD ____ /YYYY ____

Social Security Number _____ - _____ - _____ Telephone _____

E-Mail Address _____ Sex F - Female M - Male

Address Line 1 _____

City _____ State _____ Zip _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number ____ (____) _____

Name of Insured _____ Patient Relationship to insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____ /DD ____ /YYYY ____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number ____ (____) _____

Name of Insured _____ Patient Relationship to insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM ____ /DD ____ /YYYY ____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____



Consent for Treatment and Payment Agreement

I hereby authorize **Westside Primary Care @ Sunrise** to use and/or disclose my health information which specifically identifies me or which can reasonable be used to identify me to carry out my treatment, payment and healthcare operations.

Payment includes but is not limited to: the authorization of payment directly to **Westside Primary Care @ Sunrise** of benefits otherwise payable to me. I hereby acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury to my employer or designee understand that I am financially responsible for charges not covered. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment and the quality of that care.

I understand that this is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation. A photocopy of this consent shall be considered as valid as the original.

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file with your insurance; however, you are responsible for your co-pay and or percentage which the insurance is not responsible for on the day of your visit. It is the patient's responsibility to obtain any necessary referral forms from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient/guarantor we will place your account with a collection agency which will leave you liable for any additional charges incurred.

I have fully read and understand the above payment policy. I agree to forward to Westside Primary Care @ Sunrise, all insurance or third party payments that I receive for services rendered to me immediately upon receipt.

I assign the benefits payable for services to Westside Primary Care @ Sunrise

I request this authorization also apply to all other insurance.

Patient Initial: _____

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

Patient Initial: _____

RELEASE OF MEDICAL INFORMATION

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals to leave the exam room at any time.

Name of Person who is <u>Authorized to receive information</u>	Release info (please circle)	Allowed in exam room (please circle)
_____	Y N	Y N
_____	Y N	Y N
_____	Y N	Y N

***If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure**

I acknowledge that I have been given Westside Primary Care @ Sunrise Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Facility Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature _____

Date _____

Financial Policy



(please read and sign)

As your physician(s), we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy.

You will be required at each visit to present the office with your insurance card. You are also expected to notify us of any changes in name, address, phone or insurance information. Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments and any deductible required at the time of visit.

Unless arrangements have been made in advance, **co-payments, co-insurance and any outstanding balances are expected at the time of service.** Patients may be financially responsible for payment of all services, even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections or legal procedures.

If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Patient accounts not paid promptly are subject to third party collections or legal procedures.

We are participating Medicare providers and we will file Medicare for you. We request that any service routinely not covered by Medicare (i.e., Preventative Exams) be paid at the time of service. We request payment for 20% of allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.

We also do not accept Letters Of Protection on an auto liability case. We do not participate in the treatment of illnesses in Worker's Compensation claims.

Any check returned from the bank will result in an additional (\$20) charge that will appear on your account.

We must emphasize that our concern is with you and your health, not with your insurance company. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact our office promptly for assistance in the management of your account.

If at any time you have any unanswered questions or concerns, please feel free to address those issues directly with our Office Manager.

Patient

Date

Witness

Date

ALLERGIES

Do you have any allergies to the following? **(Please check all that apply and explain below)**

Medications _____

Iodine _____

Shellfish/Seafood _____

Foods _____

Other _____

FAMILY HISTORY

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Mother				
Father				
Sister				
Sister/Brother				
Sister/Brother				
Son/Daughter				
Son/Daughter				

SOCIAL HISTORY

Do you smoke?

- Yes, I have smoked _____ packs of cigarettes per day for _____ years.
- No, I have never smoked.
- No, I quit _____ years/months ago. At the time I smoked _____ packs a day for _____ years.
- Yes, I smoke a cigar or pipe.

Do you use recreational drugs? () Yes () No **(If yes please list below)**

Do you drink Alcohol?

- Yes, () Daily () 1 or more times a week () 1 or more times a month.
- No, never or rarely
- No, but I used to

MEDICAL HISTORY

Do you currently or have you ever had problems with any of the following
(PLEASE CIRCLE YES or NO)

Constitutional

Fever	Yes	No
Weight Loss	Yes	No
Excessive Fatigue	Yes	No

Eyes

Do you wear glasses	Yes	No
Infections/Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No

Ear, Nose, Throat and Mouth

Wear Hearing Aids	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Balance Disturbance	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular

Chest Pain or Angina	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
Swelling in feet or hands	Yes	No
Leg Pain while walking	Yes	No

Respiratory

Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Bloody Sputum	Yes	No

Gastrointestinal

Indigestion	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

Genitourinary

Urinary Tract Infections (UTI)	Yes	No
Painful Urination	Yes	No
Blood in Urine	Yes	No
Difficulty Starting/Stopping Stream	Yes	No
Incontinence	Yes	No
Prostate Cancer (Males)	Yes	No
Endometriosis (Females)	Yes	No
Uterine or Cervical Cancer (Females)	Yes	No

Musculoskeletal

Broken Bones	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No

Integumentary

Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Tenderness or Swelling	Yes	No
Nipple Discharge	Yes	No

Neurological

Fainting Spells or Blackouts	Yes	No
Seizures	Yes	No
Problems with Memory	Yes	No
Disorientation	Yes	No
Difficulty with Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Poor Coordination in Arms and or Legs	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Increase in Appetite	Yes	No
Excessive Thirst	Yes	No
Hormone Problems	Yes	No

Hematologic/Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/Lymph Nodes	Yes	No
Blood Transfusions	Yes	No

If yes, when? _____

PAST SURGICAL HISTORY & PREVIOUS HOSPITALIZATIONS

Please list any surgeries and/or hospitalizations. Please include date and complications if any.

Please list any major illnesses and or injuries. _____

**THE ABOVE INFORMATION IS ACCURATE TO THE BEST OF MY
KNOWLEDGE**

Patient's Signature: _____ Date: _____

I HAVE READ AND REVIEWED THE ABOVE INFORMATION

MA's Signature: _____ Date: _____