# **Tri-Valley Internal Medicine Group** New Patient Registration Form

# **Patient Information**

Patient's Last Name	First Name		MI	Sex $\Box$ M $\Box$ F
Patient's Date of Birth	Age		Social Security # (Billing	/Identification Purpose)
Race	Ethnicity		Primary Language	
Patient Address				
City	State	Zip		
( )	( )		( )	
Home Phone Number	Cell Phone		Work Phone	
Responsible Party (if patient is a minor)			Relationship	
Spouse's Last Name	First Name		D.O.B.	
Spouse's SSN (if Subscriber)	Spouse's Contact Nun	nber		
			()	
Emergency Contact	Relationship		Phone Number	
Employer Name	Contact		Phone Number	
Employer Address	City	State	Zip	
Preferred Pharmacy	Street		City	
How did you hear about our practice?				
	Incura	nce Informa	ation	
	insul a			
Would you like for your insurance to be bille	d? □Yes □No	Are you the	subscriber of the insurance?	Yes 🗆 No
Name of Primary Insurance				
Name of Subscriber		Relationship	)	
Subscriber ID #		Subscriber l	D.O.B	
Name of Secondary Insurance (if applicable)	)	Subscriber 1	D#	
Name of Subscriber		Relationship	)	

## **Please Initial All Below**

\_I authorize the release of any medical information to process claims.

\_\_I authorize the release of payment for medical benefits to Healthcare Crossing Medical Corporation (TVIMG).

\_\_\_\_\_I hereby consent to and authorize the performance of all treatments, surgery, and medical/behavioral health services by the staff of TVIMG which they may deem advisable. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage.

\_\_\_\_\_I furthermore agree to pay legal interest, collection expense, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize TVIMG to release information requested by my insurance company and/or its representatives.

\_\_\_\_I authorize TVIMG to leave messages on my answering machine regarding appointments and test results.

\_\_\_\_\_I authorize TVIMG to photograph me and/or my medical condition for my electronic medical records. This photograph may be used for used for educational purpose or medical research with my consent.

\_\_\_\_\_I hereby acknowledge the HIPPA (Notice of Privacy Practices) from TRI-VALLEY INTERNAL MEDICINE GROUP is available upon request. I have been given the opportunity to read and ask questions regarding the Privacy Policy Statement found within this registration packet.

\_\_\_\_\_I hereby authorize TriValley Medical Group to obtain my medication history from the SureScripts/DOJ network.

\_\_\_\_\_I understand that my appointment will be rescheduled if I arrive 15 or more minutes late to my scheduled appointment.

\_\_\_\_\_I understand that there is a 72 hour turn around for prescription refill requests. IF YOU REQUIRE A PRESCRIPTION REFILL, PLEASE CONTACT YOUR PHARMACY TO INITIATE THE REQUEST.

\_\_\_\_\_I understand that there is a \$15.00 fee for all personal paperwork completed by a physician (EDD Forms, DMV Forms, etc.), forms will be completed within 72 hours.

\_\_\_\_\_I understand that TriValley Internal Medicine offers secure online access to my chart summary and results through the Patient Portal. I understand that only one email address can be used per account. I will be given instructions for registering upon completion of this form.

I would like to sign up for the TriValley Patient Portal: Yes No

Patient E-mail address (only one email address per Patient Portal account)

I give the physicians and office staff of TVIMG permission to discuss my medical condition with the following persons:

Name	Relationship
Name	Relationship
Name	Relationship

Signature of Patient or Guardian

Date

### **Medicare Only**

\_\_\_\_\_I certify that I am not a member of any capitated Health Maintenance Organization (HMO), other than Tri Valley Medical Group. I further understand that membership in such a program prevent Medicare from covering my expenses for services provided by TVIMG and that I would be fully responsible for those uncovered charges.

\_\_\_\_\_I request that payment of authorized Medicare benefits be made to TVIMG. I authorize any holder of medical information about to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable to relate service.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

\_\_\_\_\_\_With Medicare assigned cases, TVIMG agrees to accept the allowed amount determined by Medicare and the patient is responsible only for the deductible, coinsurance and non-covered services. Co-insurance and the deductible are based upon the allowed amount by the Medicare carrier.

## **Medical/Social History**

Patient Last Name	First Name		MI	
Place of Birth	Occupation			
Marital Status:  Single Married Divorce	ed 🗆 Widowed 🗆 Separated	Number of Children:	Boys	Girls
Tobacco Use:  Ves No Quit	x per day x	years, specify type:		
Alcohol Use:  Ves  No  Quit	x per day x	years, specify type:		
Do you have any allergies to any medications?	Yes 🗌 No If so, please specif	fy Medication Name and Type/S	Severity of Reaction:	
Are you currently taking any medications?	□ No If so, please specify:			
Medication Name/Strength	Medical Condition			Year Diagnosed

Have you had any surgeries or operations?  $\hfill\square$  Yes  $\hfill\square$  No  $\hfill$  If so, please specify:

Family History of Illness and/or Medical Conditions (If deceased, please specify and note at what age):

ather Medical Conditions, Age	Siblings Medical Conditions, Age
at.	her Medical Conditions, Age

#### Patient Last Name

First Name

MI

Health Screening (Date, was th	he result normal?):
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Last Physical Exam	Last Cholesterol	Last Complete Blood Test
Last Colonoscopy	Last Prostate Exam	Last PSA
Last Mammogram	Last Pap Smear	Last Angiogram
Last Stress Test	Last Flu Vaccine	Last Pneumovax

### Current Review of Systems (Circle Yes or No):

General		Gastrointestinal	
Weakness	Y/N	Heartburn or Indigestion	Y/N
Unexplained Weight Loss	Y/N	Nausea or Vomiting	Y/N
Persistent Fever	Y/N	Diarrhea	Y/N
		Constipation	Y/N
Skin		Blood in Stool	Y/N
Jaundice	Y/N	Abdominal Pain or Cramps	Y/N
Hives, Eczema or Rash	Y/N	Belching or Excessive Gas	Y/N
Frequent Boils or Infections	Y/N	Abdominal Distention	Y/N
Abnormal Pigmentation	Y/N	Early Satiety	Y/N
Easy to Bruise	Y/N	Loss of Appetite	Y/N
Head-Eyes-Ears-Nose-Throat		Genitourinary	
Double Vision or Blurry Vision	Y/N	Frequent Urination	Y/N
Floaters	Y/N	Painful Urination	Y/N
Loss of Hearing	Y/N	Loss of Urine Control	Y/N
Ringing in Ear	Y/N	Difficulty Initiating Urine	Y/N
Loss of Smell	Y/N	Blood in Urine	Y/N
Frequent Nosebleeds	Y/N	Impotence	Y/N
Headaches	Y/N	Loss of Libido	
Hoarseness	Y/N	Pain with Intercourse	
Breast		Loco motor-Musculoskeletal	
Lumps	Y/N	Muscle Cramps	Y/N
Discharge	Y/N	Painful Joints	Y/N
Tenderness	Y/N	Swollen Joints	Y/N
		Morning Stiffness	Y/N
Cardiovascular		Weakness or Numbness	Y/N
Chest Pain during Exertion	Y/N		
Short of Breath Lying Down	Y/N	Endocrine	
Decrease Exercise Tolerance	Y/N	Thyroid Problems	Y/N
Swelling of Hands or Ankles	Y/N	Excess Thirst	Y/N
Palpitations	Y/N	Excess Urination	Y/N
Heart Murmurs	Y/N	Heat Intolerance	Y/N
Legs Cramp with Walking	Y/N	Cold Intolerance	Y/N
Lightheadedness or Syncope	Y/N	Hot Flashes	Y/N
Respiratory		Neurologic	
Chronic Cough	Y/N	Convulsions	Y/N
Asthma or Wheezing	Y/N	Memory Loss	Y/N
Blood in Sputum	Y/N	Poor Coordination or Frequent Falls	Y/N

## **Advance Directive Status**

Patient Last Name		First	MI	Date of Birth
This form is opti request.	onal. If you should choose	e to have an Advance Dire	ective, additional forms a	and information will be made available upon
	orm, I have acknowledged the execution of an Advance		d of my right to formulat	e an Advance Directive. Information is available
Please initial one	of the following:			
	I have previously comp	leted an Advance Direct	ive and have provided a	a copy for inclusion on my record.
	A copy of my Advance l	Directive is on file with _	Name of Physician or Fac	ility
	I have not included my	Advance Directive and l	am not interested in a	ny further information.
	I am interested in the fo provider.	ormulation of an Advanc	ce Directive and will dis	scuss my options with my primary care
Additional Com	nents Pertaining to Advand	ce Directive:		
Patient Signature			Date	
Office Use Only***	*****	*****	****	*****
	The patient was given a b	prochure/additional inform	nation regarding Advanc	e Directive.
Staff/Witness Signa	ture		Date	

Privacy Policy Statement Tri-Valley Internal Medicine Group 39765 Date Street Ste 102 Murrieta, Ca 92563 Privacy Officer: Lauren Hopewell, Office Manager

**Purpose:** The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

#### Effective Date: 09/23/2013

It is the policy of this medical practice that we will adopt, maintain and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.

#### **Notices of Privacy Practices**

It is the policy of this medical practice that a notice of privacy practices must published, that this notice be provided to all subject individuals at the first patient encounter if possible, and that all uses and disclosures of protected health information be done in accord with this organization's notice of privacy practices. It is the policy of this medical practice to post the most current notice of privacy practices and to have copies available for distribution at our reception desk.

#### Assigning Privacy and Security Responsibilities

It is the policy of this medical practice that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rule's requirements. Furthermore, it is the policy of this medical practice that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of this medical practice that there will be one individual or job description designated as the Privacy Official.

#### **Deceased Individuals**

It is the policy of this medical practice that privacy protections extend to information concerning deceased individuals.

#### Minimum Necessary Use and Disclosures of Protected Health Information

It is the policy of this medical practice that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the patient or 3) as required by law for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information must needed to accomplish the purpose of the use or disclosure. It is also the policy of this medical practice that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of this organization that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

#### **Material Change**

It is the policy of this medical practice that the term "material change" for the purposes of these policies is any change in our HIPAA compliance activities.

#### Sanctions

It is the policy of this medical practice that sanctions will be in effect for any member of the workforce who intentionally or unintentionally violates any of these policies or any procedures related to the fulfillment of these policies. Such sanctions will be recorded in the individual's personnel files.

#### **Retention of Records**

It is the policy of this medical practice that the HIPAA Privacy Rule records retention requirement of seven years will be maintained in a manner that allows for access within a reasonable period of time. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

#### **Regulatory Currency**

It is the policy of this medical practice to remain current in our compliance program with HIPAA regulations.

#### **Cooperation with Privacy Authorities**

It is the policy of this medical practice that oversight agencies such as the Office of Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information with this organization. It is also the policy of this organization that all personnel must cooperate fully wit all privacy compliance reviews and investigations.