Patient Information Sheet

☐ New Patient
☐ Name Change
☐ Address Change
☐ Insurance Change
☐ Other _____

OFFICE USE ONLY
Doctor #: _____
Account #: _____
Family Member #: _____
Medical Record #: _____

PATIENT INFORMATION

Last Name	First Name	M.I.	Sex (M or F)	Date of Birth	Social Security No.

Patient's Address	Apt. No.	City	State	Zip Code

Patient's Home Telephone	Work Phone	Message Phone	Marital Status (S, M, D, or W)

CIRCLE PRIMARY CONTACT NUMBER

Patient's Employer	Employer's Street Address	City, State, Zip Code	Telephone

Language of Preference	Interpreter Required? ☐ Yes ☐ No	E-mail Address

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Decline to Provide

Race ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Unknown ☐ Decline to Provide

GUARANTOR/FINANCIAL RESPONSIBILITY INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR OR FULL-TIME STUDENT)

Father's Name (last, first, M.I.)	Father's Address (if different than patient's)

Father's Employer	Employer's Street Address	City, State, Zip

Father's Social Security No.	Date of Birth	Business Phone

Mother's Name (last, first, M.I.)	Mother's Address (if different than patient's)

Mother's Employer	Employer's Street Address	City, State, Zip

Mother's Social Security No.	Date of Birth	Business Phone

SPOUSE OR EMERGENCY INFORMATION

Last Name	First Name	Relationship to Patient	Telephone

INSURANCE INFORMATION

Primary Insurance Co.	Policy Number	Group Number	Plan Code

Subscriber Name	Date of Birth	Subscriber ID	Employer

Secondary Insurance Co.	Policy Number	Group Number	Plan Code

Subscriber Name	Date of Birth	Subscriber ID	Employer

DOES THE PATIENT HAVE ANY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE BELOW:

Insurance Co.	Subscriber	Policy Number

NEAREST RELATIVE (NOT LIVING WITH YOU)

Relative's Name	Street Address	Phone Number

Missed appointments may be subject to a charge if 24 hour prior notice is not given.

All returned checks will be subject to a $30.00 processing fee. Failure to replace and pay all returned checks and the processing fee could result in the item being turned over to the District Attorney's Office.

My signature below hereby authorizes the above named insurance company(s) to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of medical information to said insurance company. Additionally, my signature provides willing consent to the procedures which may be performed, including emergency treatment or services, and which may include but is not limited to, laboratory procedures, x-ray exams, medical or surgical treatment or procedures, anesthesia, vaccinations, or services rendered to the patient under the general and special instructions of the patient's physician or his designate.

_____ _____ _____

Signature Date If Not Patient, Relationship

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing this form, you are granting consent to Apex Med Family Healthcare to use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You may obtain a copy of the Notice of Privacy Practices by viewing our website www.apexmedfh.com or by contacting our Quality Management Department at (909)581-8509.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

To request restrictions, you must make your request in writing to Apex Med Family Healthcare Medical Records Department at 99 North San Antonio Ave Suite 210 Upland, CA 91786. Please tell us (1) What information you want to limit (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Signature (Patient / Parent / conservator / guardian)

Date

Authorization to Contact Information

PATIENT NAME: _____ **DOB:** _____

CHART NO.: _____ **DR:** _____ **APPT:** _____

Dear Patient,

You have the right to specify how and when we communicate with you about your medical care/services. For example, you can ask that we only contact you by telephone to discuss appointments, results or other medical information. Please review the following choices and indicate to us which method of communication is best for you.

STANDARD COMMUNICATION

_____ Standard Communication: All information on my account can be used to communicate with me, including address and home telephone number. My work telephone number may be used for messages.

RESTRICTED COMMUNICATION

_____ Only contact me by telephone at: _____

_____ Do not send mail to my home address. Only send written communications regarding my medical information to the address listed below:

Street: _____

Apt. or Suite: _____

City: _____ Street: _____ Zip: _____ - _____

_____ Special Instructions:

_____

_____

_____

_____

My signature below authorizes the doctor and/or staff member to communicate in the method indicated above. This includes:

- Stating that he/she is associated with the doctor's office and/or Apex Med Family Healthcare to any person or answering device that may answer the telephone.
- Sharing the information regarding my appointments, test results or other medical information with any person or answering device that may answer the telephone.

Signature: _____ Date: _____

Patient Name: _____ *MR#:* _____

Notice of Privacy Practices Patient Acknowledgement

The Apex Med Family Healthcare Notice of Privacy Practices provides detailed information about how we may use and disclose your protected health information. It also describes your right to request restrictions on how we use and disclose this information. You are being given a copy of the Notice of Privacy Practices at this time and we encourage you to read it in full.

Our Notice of Privacy Practices is also available for viewing on the website which can be accessed at www.apexmedfh.com. Additional copies may be obtained by contacting our Customer Relations Department at (909) 581-8509.

By signing below, I acknowledge that I have been given a copy of the Apex Med Family Healthcare Notice of Privacy Practices.

Signature: _____ *Date:* _____
(Patient/Parent/Conservator/Guardian)

For Staff – Use Only if Unable to Obtain acknowledgment

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment describe the good faith efforts made to obtain the individual's Acknowledgment, and the reasons why the Acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

- ☐ *Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.*
- ☐ *Other:* _____

Signature: _____ *Date:* _____ *Time:* _____

Print/Type Name: _____

Member Acknowledgement of Financial Responsibility

Patient Services

Patient Name: _____ *MRN:* _____

Date of Service: _____ *Provider:* _____

Insurance: _____ *Assigned Medical Group:* _____

Service, device, supply or equipment in question: _____

Dear Patient,

Your health plan will only reimburse Apex Med Family Healthcare for services, devices, supplies or equipment if the patient is eligible at the time of service and the services provided are a covered benefit and are medically necessary. In addition, your policy could also have an exclusion which limits coverage related to specific services. The specifics of your benefits and coverage are outlined in the Evidence of Coverage manual sent to the subscriber at the time of enrollment.

Your health plan requires Apex Med Family Healthcare to notify you when a service, device, supply or equipment may not be covered, could be deemed not medically necessary, is excluded or the patient's eligibility cannot be verified.

Your signature below acknowledges that a Apex Med Family Healthcare staff member has notified you that one or more of the following may be applicable under the terms of your health plan coverage. Where applicable you will be held financially responsible to reimburse Apex Med Family Healthcare for the following service(s), device, supply and/or equipment or the health plan requires a higher copayment or patient out of pocket responsibility:

_____ *Cosmetic Service*

_____ *Non-Covered Service, Supply, Device or Equipment*

_____ *Diagnosis (reason for visit) could be excluded or result in a higher out of pocket to the patient*

_____ *A copay or higher out of pocket could be accessed.*

_____ *Prior - Authorization has not been obtained, patient elected to proceed with service*

_____ *Eligibility could not be verified and/or obtained at the time of service.*

Apex Med Family Healthcare cannot assume financial responsibility or risk for what your coverage or benefits exclude and are deemed patient responsibility.

_____ *Date:* _____

Member or Legal Representative (please print)

_____ *Date:* _____

Signature of Member or Legal Respresentative