CENTRIC HEALTH

Patient Registration

Today's Date:_____

_____ _____ _____ _____

Last Name | First Name | MI | Date of Birth

_____ _____ _____ _____

Address | City | State | Zip Code

(___) _____ (___) _____ Gender: ☐ Male ☐ Female

Home Phone | Cell Phone

_____ _____ _____ (___) _____

Social Security # | Marital Status | Employer Name | Work Phone

Which phone numbers may we leave a message:
☐ Home
☐ Cell
☐ Work

May we use the following methods to contact you?
☐ Text
☐ Email:_____

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Hispanic
☐ Other:_____

Ethnicity:
☐ Hispanic or Latin
☐ Not Hispanic or Latin

Primary Language:
☐ English
☐ Spanish
☐ Other:_____

Responsible Party Information

Check if Same as Patient ☐

_____ _____ _____ _____

Last Name | First Name | MI | Date of Birth

_____ _____ _____ _____

Address | City | State | Zip Code

(___) _____ (___) _____ Gender: ☐ Male ☐ Female

Home Phone | Cell Phone

_____ _____ _____ (___) _____

Social Security # | Relationship to Patient | Employer Name | Work Phone

Insurance Information

(Copies of ALL cards MUST be provided)

Primary Insurance Carrier:_____ I.D.#_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

Secondary Insurance Carrier:_____ I.D.#_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

CENTRIC HEALTH

In order to better serve you and provide quality care and service please provide us with the following information:

Pharmacy Information:
Local Pharmacy Name:_____

Address:_____ Phone #:_____

Mail In Order Pharmacy:_____

Mail in Order Pharmacy Location:_____ Phone #:_____

Other Providers currently involved in your care:

Physician Name	Phone #	Specialty	Month/Year of last visit

Are you currently in a Skilled Nursing Facility? ☐ **No** ☐ **Yes; Name of Facility:**_____

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record No._____

Address:_____

Facility Name: _____

I authorize **Centric Health** to use or disclose my health information as described below.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

- ☐ Only the following records or types of health information:

_____

_____

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Centric Health to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.
Recipient: I authorize my health care information to be released to the following recipient(s):

Name : _____ Relationship _____
Address _____ Phone #_____

Name : _____ Relationship _____
Address _____ Phone #_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 20___.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule may no longer protect the information.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Distribution of copies: Original to patient's Medical Record, copy to patient.

CENTRIC HEALTH

Emergency Contact Information

Please provide us with three (3) Emergency Contacts, and whether or not we are authorized to disclose medical information.

Contact Name	Phone #	Relationship to Patient	Authorized to receive medical information?*
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

*Your indication in this section either authorizes or denies **Centric Health/Practice Name** to release or withhold confidential medical information including but not limited to appointments, conditions, and treatments to the listed individuals

This authorization shall be effective immediately and remain in effect until a written request has been submitted.

I hereby authorize the permissions as indicated above. I understand I have a right to a copy of this authorization.

Patient or Legal Representative Signature

Patients Printed Name

Relationship to Patient if other than self

Date

Patients Date of Birth

Prescription History Consent

I hereby authorize **Centric Health/Practice Name** to access and use my electronic prescription history. I understand by doing so I am allowing **Centric Health/Practice Name** to access a full electronic history of prescriptions that have been prescribed to me by any and all of my healthcare providers including but not limited to hospitals, urgent cares, dentists, and private practice physicians. I am also allowing **Centric Health/Practice Name** to access records in regard to prescriptions filled in my name by local, mail order, and specialty pharmacies.

I understand this authorization shall not expire unless I submit a written request.

Patient or Legal Representative Signature

Date

CENTRIC HEALTH

Financial Policy Agreement

Thank you for choosing our office for your medical care needs. We are part of **Centric Health**, a multi-specialty group practice, and we look forward to being your healthcare provider. We are committed to providing you with superior and quality healthcare. We appreciate your commitment to adhere to this Financial Policy Agreement. **PLEASE NOTE: This financial policy applies to ALL Centric Health Divisions.**

Patients with Medical Insurance Benefits:

It is your responsibility to provide our office with a picture I.D., and valid insurance coverage information. You must notify us of any changes in your insurance coverage immediately. Many insurance companies have timely filing limits, if you provide us with insurance information after those limits have expired, you will be responsible for those services.

We are participating in most major health plans. We have contracts with many PPO's, HMO's, insurance companies as well as government agencies including Medicare. Our business office will submit claims for any services rendered, and assist you in any way reasonable to help get your claim paid. Your insurance may delay and/or deny claim payment pending requested information from the subscriber of your plan; it is your responsibility to comply with their request. Any such delays or denials will be your financial responsibility.

Copay's, Co-insurances, and Deductibles:

All co-pays, co-insurances, deductibles, and current balances are due prior to services being rendered. If such payments are not made at the time of service, our business office will send you a statement for your balance. It can be difficult at times to offer an exact quote of your portion due, we can however offer an estimation upon request. Under no circumstances is an estimation considered final payment or payment in full. Balances on claims are not considered final until after your insurance has processed the complete claim.

Non-covered and Out-of-Network Services:

Medical services considered by your insurance company to be non-covered, out-of-network, or not medically necessary will be your responsibility. Our office will attempt to verify benefits for services provided, but it is ultimately your responsibility to know your coverage.

Patient's WITHOUT Medical Insurance Benefits:

We recognize that some of our patients may be without insurance coverage or choose to receive care from our providers even when we are not considered 'participating providers' with their health plan. We offer reasonable discounted fees, as well as payment plans. Please let us know in advance if you are in this situation so we may help determine the best way to handle your account.

Other Policies & Service Charges

Payment Plan

If at any time you are having difficulty paying your account, we encourage you to contact our business office at (661) 371-2796, to set up a reasonable payment plan. We have many options to help during your financial hardship.

Balance Policy

Our business office will send statements regularly; if you have any questions or dispute your balance, it is your responsibility to contact our business office within 30 days. Statements will include balances due for ALL Centric Practice locations. If a credit occurs for a prepaid date of service, we reserve the right to reapply that payment if there is an outstanding balance on the account. Any past due accounts may be referred to an outside collection agency, and subject to interest and a negative credit rating with various credit bureaus.

_____Patient Initials

CENTRIC HEALTH

Waiver of Patient Responsibility

It is our policy to treat all patients in a fair manner related to account balances. We will not waive, fail to collect, or discount any co-pay, co-insurance, deductible, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with our Financial Hardship Policy. Please contact our business office at (661) 371-2796 for more information.

Form Completion Policy

ALL forms requiring medical review and physician signature are subject to an administrative fee of $25.00 *per form*. This fee will be due prior to release of any completed forms.

Request for Medical Records

We require written requests for all releases of medical records. Requests for records are subject to an administrative fee of $25.00 per request plus $0.25 per page copied. We reserve the right to NOT release any records until such fees are paid.

Return Check Policy

Any check returned from the bank as unpaid, is subject to a return check fee of $25.00 per check payable by cash, money order, or credit card. We may choose to refuse future check payments on your account. In addition, we may seek all additional legal remedies provided to us under California law, including but limited to reporting your returned check to the local District Attorney's office.

Missed Appointment

We understand there may be times when you might have to miss an appointment due to other obligations or emergencies. We require at least 24 hour notice of any appointment cancellations. If a 24 hour notice is not provided it is at the discretion of the office to charge a $25 missed appointment fee. Cancelling your appointment in advance gives us an opportunity to offer medical services to another patient.

By signing this agreement:

- I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Centric health and Centric Health's representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to :
    - File medical claims with the health plan
    - File appeals and grievances with the health plan
    - Discuss or divulge any of my personal health information or that of my dependents with any third pary including the health plan.
- I certify that the health insurance information that I provided to Centric Health is accurate as of the date set forth below and that I am responsible for keeping it updated.
- I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Centric Health are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.
- I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.
- I understand this agreement will remain in effect until I have formally revoked in writing.
- I understand Centric Health's financial policy may be amended without prior notice.
- I acknowledge I have read and understand Centric Health's Financial Policy. A copy will be provided to me upon request.

Patient Name: _____ Date of Birth: _____

Patient or Legal Guardian Signature: _____

Relationship to patient, if other than self: _____

Kern Endocrine Office Policy

1. If the patient has no insurance and/or is a self-payer, they should make payment arrangements before services are rendered.

2. If the patient is a member of an insurance plan which requires a Referral/Authorization for his/her visits, the patient is responsible for obtaining the initial authorization for their visit. Failure to do so will result in unpaid charges will be billed directly to the patient.

3. If you are not able to keep your appointment, we request that you call us 72 hrs in advance, so that we may be able to provide more timely care to other patients who could be scheduled into your reserved time slot. We require at least 24 hrs notices for the cancellation of all appointments. **A $25 charge will be added to your account if 24 hrs notices is not received prior to a missed appointment. On all missed biopsy appointments you will be charged $50.00.**

4. **If you no show or same day cancel 3 times in a year, you will be dismissed from the practice and referred back to you primary care doctor for further treatment.**

5. All refills should be done during office visits. If seen within the last 60 days, you may request a prescription refill by calling your pharmacy and asking them to send us an electronic refill request. Also please plan ahead. **Prescriptions will be refilled within 72 hours of the office receiving the request. No prescriptions will be provided after hours or on weekends.**

6. Any and all paperwork or forms that the physician are requested to complete need to be done by a special office appointment. That includes, but not limited to: Dot physicals, FMLA, disability, social security etc. **There is a $25.00 charge for all forms.**

7. Please make a list of questions for your doctors/educators prior to your visit. If you have questions after you leave your visit, you must make a follow up appointment. **We cannot answer questions and treat patients over the phone.** If you mail or fax questions, they will be put in the chart to be addressed at the next visit.

8. When patients are requesting medical records, the patient must complete an "Authorization for Release of Medical Information." There is a processing fee payable at the time of request. Requests are usually handled within 15 business days

9. We accommodate walk in appointments as often as possible for patients with acute needs. If you need medical care when the office is closed, you can go to the nearest walk-in clinic. In case of an emergency, call 911 and go to the nearest emergency room.

If you have any questions regarding the above information, please ask.

Patients Signature: _____ Date: _____

Patient Printed Name: _____

PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (First, MI, Last):	Date:	Date of Birth:

Reason for referral to our practice:

MEDICAL HISTORY

☐ High Blood Pressure	☐ Heart Trouble	☐ Cancer	☐ Osteoporosis
☐ High Cholesterol	☐ Diabetes	☐ Thyroid Disorder	☐ Pituitary/Adrenal Disorder

☐ Other past or current medical condition:

Surgeries:

Hospitalizations/Major Injuries:

Significant health conditions of your family members:

☐ High Blood Pressure	☐ Heart Trouble	☐ Cancer	☐ Osteoporosis
☐ High Cholesterol	☐ Diabetes	☐ Thyroid Disorder	☐ Pituitary/Adrenal Disorder

MEDICATIONS

List your medications, including: prescribed drugs, birth control, pain medication, sleep aids, over-the-counter vitamins and supplements. (Include name, strength, frequency taken)

List Allergies or Adverse Reactions to medications or other substances below: (Include drug name and allergic reaction)

SOCIAL HISTORY

What do you do for exercise?

What do you do for relaxation?

What methods do you use to control your weight?

Do you use: (Place an X in the box next to those you use) ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Beer ☐ Wine ☐ Hard liquor ☐ Recreational drugs

SEXUAL/MENSTRUAL HISTORY

Are you sexually active? Are you using birth control? Which type?

When was your last period? Are you trying to become pregnant?

DIABETES HISTORY FORM

Please complete this form only if you have diabetes. Print and bring to your visit.

Name (First, MI, Last):	Date:	Date of Birth:

What year were you diagnosed with diabetes? How old were you?

Have you ever had any diabetes related complications? ☐ High blood pressure? ☐ Diabetic eye disease or previous laser treatment?

☐ High cholesterol? ☐ Nerve problems (numbness/tingling)? ☐ Heart attack or Chest pain /pressure with walking?

☐ Kidney problems or protein in your urine? ☐ Stroke or TIA? ☐ Foot ulcers or deformities?

☐ Pain /cramps in lower legs with walking? ☐ Dental problems or Gum disease? ☐ Erectile dysfunction?

☐ Depression?

Have you ever been hospitalized for uncontrolled blood sugar? When & where?

What insulin and other medications (names, doses, frequency) do you take for diabetes?

If you take insulin, what year did you start?

Do you check your blood sugars at home? (Please always bring your meter to your appointment)

During the past month, what have your sugars been:

Fasting/pre-breakfast sugars: Highest:_____ Lowest:_____ Average:_____

Pre-lunch sugars: Highest:_____ Lowest:_____ Average:_____

Bedtime sugars: Highest:_____ Lowest:_____ Average:_____

What year did you get your last pneumonia vaccination?_____If you have not had a pneumonia vaccination: The Centers for Disease Control (CDC) recommends that all people with diabetes receive a pneumonia vaccination to reduce your chance of getting a bacterial pneumonia infection. It protects against 23 types of pneumococcal bacteria. It is recommended once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination.

Have you had a flu shot during this flu season (between October and February)?_____If you have not had a flu shot: A yearly flu shot is recommended to people with diabetes.

When was your last eye exam? It is recommended that all people with diabetes have a yearly eye exam.

Do you smoke tobacco? If Yes, how many packs per day?

Please remember to bring your <u>blood sugar meter</u> and <u>blood sugar record</u> to your appointment. For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.

Please bring all of your medication bottles with you to your visit

CENTRIC HEALTH

NOTICE OF PRIVACY PRACTICES

ACKNOWLEGEMENT OF RECEIPT

The Centric Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

Interpreter (if applicable)