FOLSOM LAKE PRIMARY CARE
2575 East Bidwell Street Suite #210, Folsom, CA 95630
Phone: (916) 984-7850 | Fax: (916) 984-7877

New Patient Registration Packet

Patient Demographics		
How did you hear about us? _____		**Today's Date:** ____/____/____
Name (Last, First MI): _____		**SSN:** _____
Date of Birth: ____/____/____	**Age:** _____	**Gender:** M F
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Address: _____		
Email: _____	**Home Phone:** _____	**Cell Phone:** _____
Are you interested in having access to the online patient portal? Y / N		

Emergency Contact Information	
Emergency Contact Name (Last, First MI): _____	
Relationship to Patient: _____	**Phone #:** _____
Address: _____	

Insurance Information (can exclude if insurance card present)				
	Insurance Name	**Member ID**	**Group ID**	**Effective Date**
Primary				
Secondary				

Subscriber Information (the person who carries the insurance)		
Name (Last, First MI): _____		**Date of Birth:** ____/____/____
Relationship to Patient:		**Phone #:** _____

Guarantor- the person financially responsible for services (if other than patient)	
Name (Last, First MI): _____	**Date of Birth:** ____/____/____
Address: _____	**Phone #:** _____

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Past Medical History

Do you have any conditions related to the following organs? If so, please specify.

Heart	
Lungs	
Brain	
Gastro-Intestinal	
Kidney	
Urinary	
Cancer	
Other	

Have you had any surgeries? _____

List other hospitalizations: _____

List allergies: _____

Last Colonoscopy? _____ **Last Mammogram?** _____ **Last Bone Density?** _____

Immunizations:

	Flu	Prevnar 13	Pneumovax (23)	Tetanus	Shingles	Other
Date						

List Current Medications: _____
_____
_____

Family History

Please specify which relative has/had the following conditions:

Hypertension: _____	Heart Disease: _____	Diabetes: _____
Stroke: _____	Cancer: _____	Asthma: _____
Anemia: _____	Epilepsy: _____	Kidney Disease: _____
Psychiatric: _____	Tuberculosis: _____	Alcoholism: _____
Other: _____		

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Social History			
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Sexual Orientation:	☐ Heterosexual ☐ Bisexual ☐ Homosexual		
Alcohol? Y / N	_____ drinks per (day, week, month) for _____ years		Date quit: _____
Tobacco? Y / N	_____ packs per (day, week, month) for _____ years		Date quit: _____
Recreational Drugs? Y / N	Type? _____	Frequency? _____	Date quit: _____

Do you have any concerns regarding:

General (fever, chills, fatigue, weight changes): _____

Eyes (decreased vision, blurring, glasses): _____

Ears/Nose/Throat (hoarseness, hearing problems, congestion, allergies): _____
_____

Heart (chest pain, ankle/leg swelling, leg pain, palpitations): _____

Lungs (wheezing, shortness of breath, cough): _____

GI (nausea, vomiting, heartburn, diarrhea, pain): _____

Urinary (frequency, urgency, pain, blood, kidney stones): _____

Musculoskeletal (pain, swelling, limited range of motion): _____

Neurological (headaches, seizures, numbness, dizziness): _____

Psychological (depression, anxiety, sleep problems, stress): _____

Skin (rash, tags, moles): _____

Female (menstrual problems, pain during intercourse, discharge): _____
# of Pregnancies: _____ # of Births: _____ Last Menstrual Period: _____

Male (prostate problems, weak stream, impotence, discharge): _____

Other: _____

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Consent and Policy Form	
Name (Last, First MI): _____	**Date:** _____/_____/_____

TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:
I hereby voluntarily consent to outpatient care from the Folsom Lake Primary Care and its providers hereafter as (FLPC), encompassing routine diagnostic procedures, examinations, and medical treatments including (but not limited to) routine laboratory work and administration of medications as prescribed by the providers. I further consent to the performance of these diagnostic procedures, examinations, and rendering of medical treatment by the FLPC medical providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to my blood and/or bodily fluids, thus increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event that such an exposure occurs, I understand the need for testing for these diseases, and I agree to such testing for myself to promote the health and welfare of the health care workers. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize FLPC to release any information acquired in the course of my examination and treatment to any authorized agent for the purpose of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY (HIPAA):
I, undersigned, having been made aware of and have read my rights as a patient under the "Health Information Portability and Accountability Act" (HIPAA) as posted in the office. I understand that I may request a printed copy at any time.

AUTHORIZATION TO ACCESS PRESCRIPTION HISTORY INFORMATION:
I hereby authorize FLPC to access historical prescription drug information from other entities such as, but not limited to, pharmacies, hospitals, and other providers.

HEALTH INFORMATION EXCHANGES:
FLPC endorses, supports, and participates in the electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures.

Initial here to consent to participate in the HIE: _____

MESSAGE CONSENT:
I consent to have messages from FLPC left on my voicemail with my phone numbers listed above or on my emergency contact's voicemail with their provided number, unless marked below.

☐ I DO NOT consent to have health-related messages from FLPC left on my voicemail or with any other person.

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FINANCIAL POLICIES:
I authorize FLPC to file a claim with my insurance carrier for services rendered. I authorize payment of medical benefits by any insurance carrier to either FLPC or myself. I understand that insurance is a contract between myself and my insurance carrier. FLPC is not a party to this contract. We will bill your insurance carrier as a courtesy to you. In order to properly bill your insurance carrier, we require that you disclose all insurance information, including primary and secondary insurance cards, as well as any change in insurance information within 60 days of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. It is your responsibility to determine if your insurance company is contracted with us. If your insurance carrier is not contracted with us, you are responsible for paying any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If your insurance carrier pays you directly, you are responsible for payment and agree to forward the payment to us immediately. All co-payments, coinsurances, and deductibles may apply. Co-payments are the patient's responsibility at the time services are rendered. If you are uninsured, please note that your account is your responsibility. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age or older and receiving treatment, you are ultimately responsible for payment of the service.

CO-PAY POLICY:
Co-payments are due at the time of service. Co-payments that are not paid at the time of service will be charged a $10 administrative fee.

RETURNED CHECK POLICY:
A $25.00 service charge will be levied on all checks returned due to insufficient funds or for any other reason. Returned checks will not be deposited. Patient or guarantor must cover the returned check plus service charge with cash, money order, certified check or credit card payment.

NO CALL NO SHOW POLICY:
This is necessary to ensure that we are able to provide timely access for all patients with our providers as unused appointment slots delay necessary medical care for other patients in need. Scheduled appointments must be canceled or rescheduled at least 24 hours prior to the scheduled appointment time. Patients who fail to arrive for a scheduled appointment without canceling it at least 24 hours prior to the scheduled time are considered a "no-show". ***Our fee for all missed or non-cancelled appointments is $40.*** To avoid this charge, please make sure to call and cancel your appointment in due time. This way, that appointment slot can be made available for other patients.

LATE-FOR-APPOINTMENT POLICY:
To ensure our clinic runs on time and to be fair and respectful to other patients' time, we have enacted a maximum of 15 minutes late policy. *It means that if you are late for your appointment by 15 minutes or greater, we may ask you to reschedule that appointment and subsequently pay the "no-show" fee due to a wasted appointment slot that may have been used by another patient.*

ACKNOWLEDGMENTS:
I have read and agree with the above consents and policies. I understand that I may revoke this consent in writing, except to the extent that FLPC has already taken action in reliance thereof. I also understand that by refusing to sign this consent or revoking this consent, FLPC and its providers may refuse to treat me. My signature below indicates that I understand and accept the content of this form.

Signature: _____ **Date of Birth:** ____/____/____

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HIPAA-Compliant Telemedicine Informed Consent Form

Name (Last, First MI): _____ **Date:** ____/____/____

TELEMEDICINE INFORMATION:

- Telemedicine is a healthcare service provided by any means other than an in-person, face-to-face encounter. This includes but is not limited to, videoconferencing and telephone consultations. Telemedicine allows patients to have remote appointments to discuss medical and mental health information that will be used for diagnosis, consultation, treatment, therapy, follow-up, and education. This may include communication regarding highly sensitive medication information, such as HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

RISKS/LIMITATIONS:

- As Telemedicine is heavily reliant upon electronic communication, there may be some level of associated risks, which may include but are not limited to, interception or manipulation of the electronic communication, or technical difficulties. These risks may be reduced or eliminated by only using Telemedicine in a secure environment and utilizing HIPAA compliant software.
- It is my responsibility to take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- Telemedicine may limit the healthcare provider's ability to fully diagnose a condition or disease. It is my responsibility to follow the healthcare provider's recommendations - including further diagnostic testing or an in-office visit.
- Telemedicine should never be used for emergency communications or urgent requests. All emergency communications should be made directly to the office of Folsom Lake Primary Care or to the local 911 emergency services.
- To be eligible for Telemedicine, I must be residing in the state of California at the time of the Telemedicine encounter.

YOUR RIGHTS:

- Healthcare providers may choose to forward my information to an authorized third party, such as a medical specialist. Therefore, it is my responsibility to inform the healthcare provider during my appointment about any medical information that I do not wish to be transmitted through electronic communications.
- I may opt out of the Telemedicine visit at any time which will not change my ability to receive future care at Folsom Lake Primary Care.

FINANCIAL POLICIES:

- Telemedicine billing information is collected in the same manner as a regular office visit. It is my responsibility to check with my insurance plan to determine coverage.

ACKNOWLEDGEMENTS:

- I certify that the nature of this agreement has been explained to me and all my questions are fully answered, and that I have read and understood the above information regarding Telemedicine. I acknowledge that the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by myself. I also acknowledge that if I am unable to login to HIPAA compliant telemedicine visit, and desire to instead have a telephone office visit with my provider, I will be bound by this same consent and responsibilities.

Signature: _____ **Date of Birth:** _____/_____/_____