GOOD LIFE MEDICAL GROUP PATIENT REGISTRATION FORM

Please print clearly

Date____/____/____

Patient Name_____ Birth date_____ Age _____

Other name used _____ Sex: Male Female

SSN_____ Drv Lic # _____ State _____ Marital Status: S M D W

Home Address _____ Occupation_____

City_____ State_____ Zip _____ Mother's maiden name_____

Employer Name _____ Home Tel:_____

Employer Address _____ Work Tel:_____

City_____ State_____ Zip _____ Cell #: _____

Language preferred:❒ Spanish or ❒ English Pharmacy # _____

Email Address: _____

REFERRED BY: _____

EMERGENCY CONTACTS (family member / friend. Someone we may contact besides the parent with different phone number.

Name _____ Relationship _____

Home Address _____ Home Tel: _____

City_____ State_____ Zip _____ Work Tel: _____

PATIENT INSURANCE INFORMATION: do you have health insurance? ( ) Yes ( ) No **Please fill out ALL insurance info.**

Primary insurance:

Insurance Co._____

Address _____

City_____ State_____ Zip _____

Insurance Phone # _____

Subscriber _____

Subscriber DOB _____

Subscriber SSN _____

Policy # _____

Group # _____

Effective Date _____

Medical Group _____

Secondary Insurance

Insurance Co._____

Address _____

City_____ State_____ Zip _____

Insurance phone #_____

Subscriber_____

Subscriber DOB _____

subscriber SSN _____

Policy # _____

Group # _____

Effective Date _____

PCP on Insurance Card: _____

CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

I / We do here by consent to an authorize performance of all treatment, surgery and medical service by the staff of GOOD LIFE MEDICAL GROUP which they deem advisable.

I hereby certify that to the best of my knowledge, all statement contained hereon are true. I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage.

I furthermore agree to pay legal interest, collection expense and attorney's fee should it become necessary to assign any amount I may owe for collection.

I also hereby authorize the GOOD LIFE MEDICAL GROUP to release information requested by my insurance company for services rendered. I authorize all payments for these services to be paid directly to GOOD LIFE MEDICAL GROUP.

I fully understand that this agreement and consent will continue until canceled by me in writing.

Parent / Guarantor Signature:	Guarantor Relationship:	Date:

Good Life Medical Group
New Patient Questionnaire

Name: _____ Date of birth:____/____/____

Age: _____ Gender: Female / Male

Medications: Please list current prescriptions and non-prescription medicines, vitamins, herbs etc.

Name of medication	Strength	Directions

Personal Medical History: Please indicate whether you have had any of the following medical problems

Condition		Condition	
Congestive Heart Failure	❒ Yes ❒ No	Glaucoma /Cataracts	❒ Yes ❒ No
Heart Attack or Stroke	❒ Yes ❒ No	Cancer	❒ Yes ❒ No
High Cholesterol	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
High Blood Pressure	❒ Yes ❒ No	Asthma/ COPD	❒ Yes ❒ No
Depression	❒ Yes ❒ No	Thyroid Problem	❒ Yes ❒ No

Family History: Please indicate if any person, related by blood, had any of the following

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Hypertension				Glaucoma			
Stroke				Cancer			
Heart Disease				Alcoholism			
High Cholesterol				Asthma/ COPD			
Diabetes				Depression/ Suicide			

Other physicians/specialist currently seeing & reason:

1. _____
2. _____
3. _____

Allergies or reactions to medications: _____

History of past Surgeries:

Date	Reason for Surgery	Hospital/ Location

Vaccines up to date: ❒ Yes ❒ No **Note**: please give the front office vaccine records to be copied
Date of last vaccine received: ____/____/____ Name of last vaccine received:_____

Preferred method of contacting patient:

❒ Phone: _____ ❒ Mobile number ❒ Home number ❒ Work number
❒ Mail: ❒ Yes ❒ No Note: US postal service First class mail- 3 business days or less
❒ patient portal: ❒ Yes ❒ No Patient is responsible for account access, required log in to access record. If account becomes locked you may contact our office to unlock the account, changes may take 4-6 hours to reflect. The staff **does not** have access to individuals portal account.

Good Life Medical Group

3650 East South Street
Suite #204
Lakewood, CA 90712
Tel:(562) 602-8841

5451 La Palma Avenue
Suite #16
La Palma, CA 90623
Tel: (562) 602-8841

www.goodlifemedicalgroup.com

Cancellation and No show policy
Effective 10/01/2014

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide a minimum of 24 hour notice. Please call our office to speak with our scheduling department **during office hours only** to cancel or reschedule your appointment. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are canceled, with less than 24 hours notification will be subject to a **$20.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as **NO SHOW.**

Cancellation charges are not covered by insurance and are due and payable prior to any appointments.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (562) 602-8841.

_____
Patient Name [Print]

_____ _____
Patient Signature Date

Notice of Privacy Practices Acknowledgment

Good Life Medical Group Inc

I understand that, under the Health Insurance portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name:_____

Patient Representative:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" but was unable to do so, as documented below:

Date:	Initials:	Reason:

GOOD LIFE MEDICAL GROUP

Dear Patient,

Internet has revolutionized the way we communicate. We are shifting the way we communicate with our patients form phone model to internet model for a quicker and more meaningful responds through a secured patient portal.

Through this safe portal, you will be able to:

1) leave message to and receive message from our physician, physician assistant, nursing staff and billing personal;
2) make appointments through the portal anytime of the day
3) check your lab results and keep a copy on your own
4) tons of medical knowledge about how to get healthy
5) tons of information about you medical problems
6) what to do when you are sick
7) request for lab works
8) request for referrals
9) request for refills of your medications
10) Look up benefits and potential side affects of your medication

Please write down your e-mail address in the space below and hand it back to our receptionist, you will received the internet address of our portal, user name and password at the end of the visit from our receptionist.

patient(s)'s name(s): _____

patient or parent's e-mail address: _____