ID Southern California ID Associates, Inc.

NEW PATIENT FORM

Today's date:		**Reason for Referral:**	
Pharmacy Name, Address, Number:		**Referring Doctor:**	
		Primary Care Physician:	
PATIENT INFORMATION			
Patient's last name: **First:** **Middle:**			**Marital status** (select one) ◯ Single ◯ Married ◯ Divorced ◯ Sep
Birth date:	**Age:**	**Sex:** ◯ M ◯ F	Social Security **#:**
Street address:			
City:		**State:**	**ZIP Code**
Email:			**Home Phone**
Occupation:			**Cell Phone:**

IN CASE OF EMERGENCY		
Name of local friend or relative:	**Relationship to patient:**	**Phone Number:**

MEDICATIONS	
Are you currently taking any prescription or non-prescription medications?	◯ **Yes** ◯ **No**
If yes, please list your medications:	

MEDICAL HISTORY FORM

Patient Name: _____

ALLERGIES

Do you have any allergies to medications? ◯ Yes ◯ No

If yes, please list:

Do you have any of these medical conditions?

Asthma, Bronchitis, or Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Coronary Heart Disease	☐ Yes	☐ No	Chest pain	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Numbness or Tingling	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Dizziness of Fainting	☐ Yes	☐ No
Stroke/TIA	☐ Yes	☐ No	Weight Loss/Energy Loss	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Sleeping Problems	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Bowel or Bladder Problems	☐ Yes	☐ No
Blood Clot/Emboli	☐ Yes	☐ No	Vision or Hearing Difficulties	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Joint Pains	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Muscle Pains	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Skin Rashes	☐ Yes	☐ No
Depression or Anxiety	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Autoimmune conditions	☐ Yes	☐ No	Sexually Transmitted Infections	☐ Yes	☐ No
Cancer or Chemo/Radiation	☐ Yes	☐ No	Do you use tobacco?	☐ Yes	☐ No
Do you have a pacemaker?	☐ Yes	☐ No	Do you drink alcohol?	☐ Yes	☐ No
Joint Replacement Surgery	☐ Yes	☐ No	Do you use any illicit drugs?	☐ Yes	☐ No
Pins or Metal Implants	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No

Please list any other information that you feel would assist us in your care:

PRIVACY PRACTICES

Use and Disclosure of Your Protected Health Information
The privacy of your medical information is important to us. Your protected health information will be used by Southern California ID Associates, Inc. and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.
Southern California ID Associates, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If Southern California ID Associates, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Southern California ID Associates, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Southern California ID Associates, Inc. to use and disclose my health information in accordance with it.

_____ _____
Printed Name **D ate**

_____
Signature

Email Use
The physician and office staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, Southern California ID Associates, Inc. cannot guarantee the security and confidentiality of email communication, and will not be liable for improper disclosure of confidential information that is not direct result of intentional misconduct of the physician and staff. Thus, patients must consent to the use of email to disclose patient information.

Signature of Consent of Email Use_____ **Date**_____

FINANCIAL RESPONSIBILITY DISCLOSURE

Your signature below forms a binding agreement between Southern California ID Associates, Inc. and the Patient who is receiving medical services, or the Responsible Party for dependent patients. Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

Medical Insurance

We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. When we receive an explanation of benefits from your insurance company, any amounts that you need to pay will be billed to you.

Patient and/or Responsible Party must:

• Inform us of the current address and phone number for the patient and the responsible party.

• Present all current insurance cards prior to each office visit.

• Verify at each visit that the information is current by signing our data sheet.

• Pay any required copay at the time of the visit.

• Pay any additional amount owing within 30 days of receiving a statement from our office.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Southern California ID Associates, Inc. has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for dependent patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____

Printed Name **Date**

_____

Signature

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment

To cancel your appointment, please call 949-515-3590. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice.

No Show Policy: A "no-show" is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". This includes arriving 15 minutes after your scheduled appointment.

I am aware that the "no-show/cancellation" fee is $75 for new consultation, and $50 for a follow-up visit.

Patient Signature_____ **Date**_____