TRINIDAD MEDICAL CORPORATION

Internal Medicine
Emergency Medicine
Occupational Medicine

Jose R. Sanchez, MD

4800 Manzanita Ave Suite B-3
Carmichael, CA 95608
Tel (916) 481-3042 / Fax (916) 481-3044

PATIENT REGISTRATION FORM

I-a. Patient Information

Patient Name *Last Name, First Name, Middle Initial*			Date of Birth *MM / DD / YYYY*
SSN	Marital Status	Married / Single / Divorced / Widow	Sex M / F
Address *Street*		*City*	*State* *Zip*
Home Phone ( )		Cell Phone ( )	
e-mail Address		Driver License # / State	

I-b. Patient Employer Information

Employer Name			
Occupation			
Phone # ( )		FAX #	( )
Address *Street*		*City*	*State* *Zip*

I-c. Emergency Contact Information

Emergency Contact Name		Relationship	
Home Phone	( )	Cell Phone	( )
Address *Street*		*City*	*State* *Zip*

II. Financially Responsible Party

(Self / Other)

[If you check the self box, please skip this section and go to next page at section III.]

Name *Last Name, First Name, Middle Initial*			Date of Birth *MM / DD / YYYY*
Relationship to Patient	SSN	Driver Lic. #	Sex M / F
Address *Street*		*City*	*State* *Zip*
Home Phone (		Cell Phone	( )

III. Insurance Information

a. Primary Insurance

Insurance Name			In-Network / Out-of-Network
Address *Street*		*City*	*State* *Zip*
Phone ( )		FAX ( )	
Subscriber Name	Date of Birth	Sex M / F	Relationship to Patient
ID Card # (Including alpha prefix)	Group #		Authorization #
Effective Date			Co-Pay **$**

b. Secondary Insurance (if applicable)

Insurance Name			In-Network / Out-of-Network
Address *Street*		*City*	*State* *Zip*
Phone ( )		FAX ( )	
Subscriber Name	Date of Birth	Sex M / F	Relationship to Patient
ID Card # (Including alpha prefix)	Group #		Authorization #
Effective Date			Co-Pay **$**

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Sanchez to submit claims to my insurance company and request payment for services rendered. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to said insurance company. I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for all outstanding balances for the patient regardless of insurance coverage.

Patient Signature Date

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Financial Policy

Thank you for choosing Trinidad Medical Corporation to assist you with your health care needs. We strive to provide you with the best care possible, and, in return, we ask that you assist us not only in monitoring your health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement and feel free to ask us any questions you may have relating to our policy. Then sign the statement at the bottom of this form.

Acceptable Payment Methods:

We accept cash and checks. If you need additional information on that, please talk to our staff.
Most insurance programs are accepted. Please see details below.

- **Insurance:** Our office accepts assignment of benefits from many insurance companies, PPO programs. However, we **do not** accept all benefit programs. Therefore, please inquire as to whether or not your insurance company, PPO (call it to make sure) is accepted by this office when taking into account what method of payment you will want to use.

  We do require that your co-payment or deductible be made at the time of service. In the event that we do not accept assignment of benefits from a particular insurance company, PPO, we require that you pay your bill in full at the time of each visit or be pre-approved on our extended payment plan.

- **Your bill is your responsibility.** If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. Unless you are on an extended payment plan, we expect payment in full within 45 days of being notified of any balance due.

  Please be aware that some services provided may be non-covered services and are not considered reasonable and necessary under the Medicare Program and/or other insurance company, PPO, or other benefit programs. (**Note:** All laboratory tests, injections, ultrasounds, procedures, or any testing is not included as part of an office visit and will result in additional expenses.

- **Adult Patients:** Adult patients are responsible for payment at the time of service.
  Minor Patients: The adult accompanying a minor and the parents/guardian of the minor are responsible for the full payment at the time of service.

Usual and Customary Rates: We are dedicated to providing the best treatment for our patients and we charge what is usual and customary for our area of the country. You are responsible for payment regardless of any insurance company's (or any other benefit program's) arbitrary determination of what are usual and customary rates.

Missed Appointments: Our policy is to charge for missed appointments; those appointments that are not canceled at least 24-hours in advance. The charge is $35.00 (Thirty five dollars). Please help us serve you better by keeping all scheduled appointments.

I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions as stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, PPO, or other benefits programs and that I am ultimately responsible for payment in full for any outstanding balances incurred.

Patient Name: _____

Patient Signature: _____ **Date:** _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.

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HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you.

However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or health care operations.

2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.

3) The practice reserves the right to change the notice of privacy practices.

4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.

5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The Consent is signed by: _____

Printed Name (Patient name or representative)

_____ _____

Signature Date

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Treatment Agreement for Suboxone

As a participant in the buprenorphine protocol for treatment of opioid abuse and dependence, I freely and voluntarily agree to accept this treatment agreement/contract, as follows:

I agree to keep, and be on time to, all my scheduled appointments with the doctors, associates and assistants.

I agree to conduct myself in a courteous manner in the physician's office.

I agree not to arrive at the office intoxicated or under the influence of drugs. If I do, the doctor will not see me, and I will not be given any medication.

I agree not to sell, share, or give any of my medication to another individual. I understand that such mishandling of my medication is a serious violation of my treatment program and would result in my treatment being terminated. I agree not to conduct any illegal or disruptive activities in the doctor's office.

I agree that my medication (or prescriptions) can be given to me only at my regular office visits. Any missed office visits will result in my not being able to get medication until the next scheduled visit.

I agree that the medication I receive is my responsibility and that I will keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of the reasons for such loss.

I agree not to obtain medications from any physicians, pharmacies, or other sources without informing my treating physician. I understand that mixing my prescribed drugs with other medications, especially drugs of abuse, can be dangerous and even fatal.

I agree to submit to any urine, drug or other tests required by my doctor. These tests will incur additional charges and I will be responsible to cover the costs. Failure to do so can result in termination of my treatment at Trinidad Medical Corporation.

I understand that medications alone are not sufficient treatment for my disease, and I agree to participate in the patient education and second opinions to assist me in my treatment.

Printed Name: _____

Signature: _____ Date: _____

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MEDICAL HISTORY
SUBOXONE HISTORY

NAME: _____ DOB: _____

Describe your drug use. When it began, how much, how often and what kind of opiates are used. Include how they were used; by mouth, crushed and snorted, skin popped or intravenous. What was the last opiate used, how much and how: (Use the back of page if needed.)

What other drugs have you ever used? Provide what kind and how often, even if you tried them only once.

What kind of problems do you have associated with your drug use: Legal, family and or financial?

Describe anybody in your family with chemical dependency problems.

What medications are you taking now and how many times a day? Include dosages.

Have you ever been to rehab or Methadone programs?

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Are you allergic to any medications?

Do you suffer from any chronic illnesses? _____

How many times have you been hospitalized? For what reason? For how long?

How many surgeries have you had? List the year(s) of the surgeries.

Have you ever broken any bones?

Have you ever had any blood transfusions? _____

Family History

List the ages of Father____ Mother ____ How many siblings ___

How old are they ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ____

Is there anybody in your family that suffers from?
___ Diabetes ___Tuberculosis ___Heart Disease ___High Blood Pressure
___ Seizures ___Allergies ___Blood disorders ___High Cholesterol
___ Asthma ___Cancer ___Depression ___Kidney Disease
___ Hearing Problems ____Speech Problems ___Mental Retardation
___ Back or disc problems.

REVIEW OF SYSTEMS

Do you have any unexplained? Mark Y for yes and N for no.

General: ___Fevers ___Chills ___Sweats ___Weight Loss ___Weight gain ___Fatigue
___Loss of appetite ___General state of health ___Sense of well-being
___Strength ___Ability to conduct usual activities ___Exercise tolerance

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Skin: ___Itching ___Changes in color of skin ___Moisture or dryness
___Nail changes ___Changes in skin texture ___Rashes ___Flushing
___Changes in hair growth or loss ___Unusual moles ___Excessive sweats
___Poor wound healing ___Unusual hair growth or loss

Breasts: ___Breast lumps ___Tenderness ___Swelling ___Nipple discharge

Head: ___Headaches (location, time of onset, duration, precipitating factors)
___Lightheadedness ___Vertigo

Neck: ___ Stiffness ___Neck pain ___Neck tenderness ___Masses in thyroid

Eyes: ___Blurred vision ___Loss of vision ___Eye irritation ___Halos around lights
___Double vision ___Eye pain ____Discharge ___Light sensitivity ___Tearing
___Blind spots

Ear/Nose: ___Ringing in ears ___Ear Discharge ___Ear pain ___Decreased Hearing
& Throat: ___Nasal Congestion ___Nosebleeds ___Nasal discharge ___Glasses worn
___Sore Throat ___Hoarseness ___Problems Swallowing ___Frequent colds

Mouth: ___Dental difficulties ___bleeding gums ___Do you wear dentures?

Cardiac: ___Chest pain ___Lightheaded ___Near Fainting ___Palpitations ___Fainting
___Swelling of hands/feet ___Leg cramps with exertion ___Bluish lips or nails
___Difficulty breathing at night ___Racing or skipped beats ___Easily fatigued
___Easily short of breath ___Difficulty breathing while lying down ___Phlebitis
___Wake up short of breath ___Hypertension ___Heart murmurs __Varicosities

Respiratory: ____Sleep disturbances due to breathing ___Coughing blood ___Cough
____Excessive sputum ___Chest discomfort ___Excessive Snoring
___Wheezing ___Easily short of breath ___Frequent respiratory infections
___Tuberculosis (or exposure to tuberculosis) ___Fever or night sweats

Gastrointestinal: ___Excessive appetite ___Vomiting blood ___Yellowish skin color
___Abdominal bloating ___Nausea ___Gas ___Loss of appetite
___Constipation ___Hemorrhoids ___Constipation __Diarrhea
___Blood in stool ___Indigestion ___Vomiting ___Abdominal pain
___Dark or tarry stools __Ulcers ___Pain on swallowing
___Allergies to food ___Frequent heartburn ___Frequent burps
___ Abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling)
___Excessive passing gas ___Recent changes in bowel habits
___Gallbladder problems ___Diverticulitis or diverticulosis

Genitourinary: ___Urgency ___Frequent urination ___ Pain on urination ___Nephritis
___Frequent night urination ___Blood in urine ___Frequent urination
___Unusual (or change in) color of urine ___Kidney stones ___Impotence
___Kidney infections ___Difficulty voiding ___Change in size of stream
___Dribbling ___Acute retention ___ Incontinence ___Change in libido
___Change in potency ___Genital sores ___Genital discharge

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___History of venereal diseases ___Bladder stones ___Incomplete voiding
___Unusual color of urine

Females Only: **___Age of onset of periods ___Are periods regular ____Date of last period**
___Any pain with periods ___Any heavy bleeding ___Any long periods
___Any vaginal discharge ___Any bleeding after menopause
___Any pain on intercourse? ___Date of last Gynecologic exam
___Number of pregnancies ___How many live births ___Miscarriages
___Abortions ___ Rh incompatibility

Musculoskeletal: **___Muscle pain ___Joint swelling ___Joint redness ___ Cramps**
___Heat of muscles or joints ___ Inability to move ___Gout
___Muscular weakness ___Shrinking of muscles
___Fluid in joints

Neurologic: **___Convulsions ___Paralysis ___Tremor ___Loss of coordination**
___Numbness ___Difficulty with memory ___ Difficulty with speech
___Disturbances of sensation ___ Disturbances or movements
___Any problems holding urine or stool ___History of head trauma
___Weakness ___Fainting ___Difficulty concentrating
___Daytime sleepiness

Psychiatric: **___Moodiness ___Nervousness ___Emotional problems**
___Anxiety ___Depression ___Previous psychiatric care
___Unusual perceptions ___Hallucinations ___Insomnia
___Thoughts of suicide ___Thoughts of violence ___Sense of danger

Allergic: **___Reactions to food ___ Reactions to insects ___Anaphylactic shock**

Immunologic: **___Anemia ___ Prolonged bleeding after surgery**
___Use of blood thinners
___Any blood transfusions with reactions ___Blood type if known

Lymphatic: **___Local or general lymph node enlargement or tenderness**

Endocrine: **___Hormone therapy ___Abnormal growth ___Osteoporosis**
___Abnormal secondary sexual development
___Any intolerance to heat or cold

Rheumatologic: **___Sensitivity to the sun ___Morning stiffness ___Iritis**
___Conjuctivitis ___Sores in mouth ___Rashes to face

Habits: **___Do you smoke ___How much ___How long**
___Do you drink ___How much ___How long
___Do you use recreational drugs ___What type ___How often
___Any hobbies ___What kind
___Do you play sports ___What kind