JUNIX MEDICAL

9635 Monte Vista Ave Ste #204
Montclair, CA. 91763
Tel: 909.906.3446 Fax. 909.966.4450

PATIENT REGISTRATION: PLEASE PRINT AND COMPLETE ALL ENTRIES.

First Name: _____Last Name: _____ D.O.B:___ /___ /____
Sex: _____ SSN: _____Cell Phone:_____
Email Address:_____
Mailing Address:
_____
(Street or PO Box) (City) (State & Zip)
Martial Status: (Circle One)
Single Married Divorced Widowed
Spouses Name:_____ Spouses Phone Number:_____
Emergency Contact Name: _____Relation to Patient: _____
Lives with the patient? (Circle One) Yes / No
Phone Number: _____

PRESCRIPTION POLICY:

Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the physician in six months, the prescription will be denied.

Preferred Pharmacy*:_____ (**REQUIRED TO ANSWER**)

Pharmacy Address*:_____ (**REQUIRED TO ANSWER**)

PATIENT SIGNATURE*: _____ **DATE:** _____

AUTHORIZED REPRESENTATIVE*: _____ **DATE**:_____
(if patient is unable to sign)

PAYMENT POLICIES:

You are accountable for expenses not covered by your insurance. Please be prepared to pay any required copays at each visit. Your insurance coverage and financial responsibility are determined by your insurance provider and your policy. Your claim will be processed according to your plan's benefits, including any deductible, co-insurance, and co-pay. It's important that you understand the details of your insurance plan.

Do you have insurance? (Circle One) Yes / No
Primary Card Holder: (Circle One) Self / Spouse / Parent / Other:_____
Primary Policy Holder Name: _____
Primary Insurance Name: _____
Primary ID Number: _____
Primary Group Number: _____
Do you have secondary insurance? (Circle One) Yes / No
Secondary Card Holder: (Circle One) Self / Spouse / Parent / Other:_____
Secondary Policy Holder Name: _____
Secondary Insurance Name: _____
Secondary ID Number: _____
Secondary Group Number: _____

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PATIENT MEDICAL HISTORY

PATIENT NAME: _____

ALLERGIES: _____

FAMILY HISTORY: _____

SURGICAL HISTORY: _____

SOCIAL HISTORY: (CIRCLE ONE)

Do you drink alcohol? YES / NO DAILY / WEEKLY
Do you smoke? YES / NO HOW MANY PACKS PER DAY: _____

List any medications you are currently taking (please include over the counter medications):

MEDICATION NAME	DOSAGE	FREQUENCY

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HIPAA Compliance Patient Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets standards for the privacy and security of protected health information (PHI). PHI includes any information about your health or healthcare services that can be linked to you. HIPAA aims to:

- Ensure the confidentiality of your health information.
- Prevent unauthorized access, use, or disclosure of your PHI.
- Provide you with certain rights related to your health information.

Consent and Authorization:

I, _____,(*patients name*) acknowledge that I have received and understand the Notice of Privacy Practices (NPP) provided by Junix Medical. I hereby give my informed consent for the use and disclosure of my PHI for the purposes of treatment, payment, and healthcare operations, as described in the NPP.

Purpose of Use and Disclosure:

I understand that my PHI may be used for the following purposes:

- Treatment: To provide and coordinate my healthcare, including consultations with other healthcare providers.
- Payment: To facilitate billing and insurance claims for services provided.
- Healthcare Operations: For administrative purposes, quality improvement, and compliance with legal and regulatory requirements.

Authorization for Other Uses and Disclosures:

I understand that any other use or disclosure of my PHI not covered by this consent will require additional written authorization from me. I have the right to revoke this consent in writing at any time, except to the extent that action has already been taken based on my prior consent.

Patient Rights:

I acknowledge that I have been informed of my rights regarding my PHI, including the right to request access to my medical records, request amendments, and obtain an accounting of disclosures.

This consent is effective upon my signature below and shall remain in effect until revoked by me in writing.

Patient's Signature: **Date:**

OR Authorized Representative: **Date:**
(IF PATIENT IS UNABLE TO SIGN)

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MEDICAL SERVICES AGREEMENT

Medical Consent:
I, the undersigned patient, hereby consent to receive medical treatments and procedures on an outpatient basis at Junix Medical in Montclair, California. These treatments and procedures may be performed by physicians, staff, or other healthcare providers and may include, but are not limited to, medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations. I understand that these services will be provided under the general and special instructions of the healthcare professionals at Junix Medical.

Financial Agreement:
I acknowledge that all charges for healthcare services and professional services provided by physicians and healthcare providers at Junix Medical are due at the time of service. Acceptable forms of payment include Cash, Visa, MasterCard, Apple Pay, and other payment methods as specified by Junix Medical. If Junix Medical is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company. Junix Medical is not involved. In order for Junix Medical to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Junix Medical will need to verify my health insurance coverage. In the event that Junix Medical is unable to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. I also understand that I am financially responsible for any services not covered by my insurance company.

Insurance Authorization and Release:
I authorize the payment of benefits by my insurance provider(s), including Medicare, and any other government-sponsored program or private health insurance plans, to be made directly to Junix Medical for any services provided to me by their healthcare providers.

Release of Medical Information:
I hereby authorize Junix Medical to release my medical information as required for the provision of medical services and for billing purposes. This may include sharing my medical records and information with relevant healthcare professionals involved in my care.

Notice of Privacy Practices:
I acknowledge that I have received and reviewed Junix Medical's Notice of Privacy Practices, which outlines how my medical information may be used and disclosed. I have been provided the opportunity to ask questions and seek clarifications about this notice.

Personal Valuables:
I understand that Junix Medical is not responsible for any personal valuables I bring to the clinic. I will take necessary precautions to safeguard my personal belongings during my visit.

Legal and Regulatory Compliance:
Junix Medical is committed to meeting the legal and regulatory requirements specific to a family practice or medical clinic. This agreement is designed to ensure compliance with all applicable laws and regulations governing healthcare services.

Patient's Consent and Agreement:
By signing below, I acknowledge that I have read and understood the terms and conditions outlined in this agreement. I agree to comply with the financial responsibilities and the consent for medical treatment as described herein.

Patient's Signature:_____ **Date:**_____

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PATIENT ACKNOWLEDGEMENT FORM

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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **NOTICE OF PRIVACY PRACTICES** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **NOTICE OF PRIVACY PRACTICES** prior to signing this consent. 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 below 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action replying on this acknowledgement.

Patient Name:_____

Signature:_____

Authorized Representative:_____

Date:_____

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Insurance Benefit Assignment/Consent to Disclose Medical Information

Medicare - Authorization & Benefit Assignment

I request that payment of authorized Medicare benefits be made to Junix Medical for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Personal Health Information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of Personal Health Information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Name of Beneficiary HIC (Medicare Number)

Insurance - Authorization & Benefit Assignment

I hereby authorize Junix Medical to furnish Personal Health Information concerning my illness and treatment to insurance carriers or other entities necessary to pay the claim, and I hereby assign to Junix Medical all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles and any amount not covered by the insurance. Laboratory, radiology and other ancillary services provided in connection with the physician's office will be billed separately.

_____

Responsible Party Signature Date

Consent to Treatment

The undersigned consents to the treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered to the patient under the general and specific instructions of the patient’s physician.

_____

Responsible Party's Signature Date

Patient's Rights

You may refuse to give consent and may object to any part of this form. If so, please ask to speak with us about that. If you choose to give consent in this document, you may revoke your consent in the future, in writing. This right, and other rights that you have in regard to your Personal Health Information use and disclosure are detailed in our Privacy Notice. If you did not receive a copy of this Privacy Notice, please ask for one and read it carefully. We value you as a patient and strive to achieve the highest standards in our service to you.

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ACKNOWLEDGEMENT

Physician: DR. RODOLFO PEREZ JR.

Address: 9635 MONTE VISTA AVE. STE 204

MONTCLAIR, CA. 91763

Telephone: (909) 906-3446

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

_____

_____

ADVANCED DIRECTIVES:

THIS ACKNOWLEDGEMENT THAT THE PHYSICIANS, OR ONE OF HIS/HER STAFF MEMBERS, HAS PROVIDED ME INFORMATION CONCERNING ADVANCED DIRECTIVES

1. I am 18 or older. (Circle one) Yes / No
2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician had provided me with written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.
3. I am aware that Advanced Directives may be any one of the following:
    a. A Durable Power of Attorney of Health Care.
    b. The Declaration in the A Natural Death Act, Ex. A Living Will
    c. I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient's Signature: _____ Date:_____

This document will become part of my medical record.