30230 Rancho Viejo Road, Suite 200 • San Juan Capistrano, CA 92675 Phone 949-443-4303 • Fax: (949) 443-4033
16305 Sand Canyon Ave Suite 255 • Irvine, CA 92618

Paloma MEDICAL GROUP

Patient Information Sheet

NAME: FIRST_____ **LAST**_____ **MI:** _____

STREET: _____ **CITY:** _____ **STATE:** _____**ZIP:** _____

HOME PHONE: ( )_____ **CELL: ( )** _____

SOCIAL SECURITY: _____ **DATE OF BIRTH:** _____

EMAIL: _____ **PREFERRED PHARMACY:** _____

SEX: ☐ M ☐ F MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

PREFERRED LANGUAGE: _____ **RACE:** _____ **ETHNICITY:** _____

EMPLOYER: _____ **JOB TITLE:** _____

EMPLOYER ADDRESS: _____ **WORK PHONE: ( )** _____

YOUR PRIMARY CARE PHYSICIAN: _____**PHONE: ( )**_____

REFERRING PHYSICIAN/PERSON NAME: _____ **PHONE: ( )**_____

PHARMACY NAME: _____ **PHONE:( )**_____

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT. IF YOU DO NOT HAVE PROOF OF INSURANCE - PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED.

FIRST NAME: _____**LAST:** _____ **MI:**_____

RELATIONSHIP TO PATIENT: _____ **DRIVERS LICENSE #:** _____

DATE OF BIRTH: _____ **EMPLOYER:** _____

EMERGENCY CONTACT

NAME: _____ **PHONE:( )** _____ **RELATIONSHIP:**_____

ASSIGNMENT & RELEASE: I HEREBY AUTHORIZE PALOMA MEDICAL GROUP TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I HEREBY AUTHORIZE PALOMA MEDICAL GROUP TO ACCESS, COMMUNICATE AND MAINTAIN MY MEDICATION HISTORY ELECTRONICALLY THROUGH ESCRIBE AND/OR OTHER ELECTRONIC PRESCRIPTION SERVICES IN CONNECTION WITH MY MEDICAL TREATMENT AND IN COMPLIANCE WITH HIPAA REGULATIONS.I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. A PHOTOCOPY OR SCANNED COPY OF THIS ASSIGNMENT AND RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

SIGNAGURE: (PATIENT OR PARENT IF MINOR) _____ **DATE:** _____

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Patient Communication Consent Form

Patient Name: _____ Date of Birth: _____

Email and Text Messaging Program Consent Form, we are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:

1. Send or receive email communication from our office
2. Receive text message appointment reminders
4. Submit patient satisfaction surveys
6. Reminder to schedule follow up visits, wellness visits, and other important ordered and recommended tests.
7. We might also occasionally send information about special clinics we are running that you might be interested in.

You may choose to discontinue your participation in our online communication system at any time simply by replying "STOP" to a text message from us. Standard text messaging rates may apply.

Cell Phone: _____ (if you wish to receive text messages)

Email: _____ (if you wish to receive emails)

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without your permission, and do not send spam. Please sign below to indicate that you agree to allow us to use this information in providing your services

Authorization to Disclose Information to Family Members/Friends

I, the undersigned, authorize Paloma Medical Group to disclose all of my medical information to the following people:_____
_____ The expiration date for this authorization is ____/____/____ unless I revoke or terminate this authorization. I understand that I have the right to revoke or terminate this authorization by submitting a written revocation to Paloma Medical Group. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. The privacy of this information may not be protected under federal privacy regulations.

Acknowledgment of Receipt of Paloma Medical Group's "NOTICE OF PRIVACY PRACTICES"

I, (*patient's name*): _____acknowledge that I have received a copy of Paloma Medical Group's notice of privacy practices. This notice describes how Paloma Medical Group may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and the rights I have regarding my protected health information.

Patient/Guardian Signature _____ Date _____

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Paloma MEDICAL GROUP

Financial Policies

Patient Name: _____ Date of Birth: _____

Thank you for choosing Paloma Medical Group. We welcome you to our office. We are able to concentrate on the practice of medicine and provide quality of care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

Insurance Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier. _____ (patient's initials).

All services rendered by Paloma Medical Group that are not a covered benefit of your insurance policy are your responsibility to pay. Any patient that is seen or treated without proper authorization from their insurance carrier is responsible for the full charge of the services rendered if no payment is authorized retrospectively. All monies owed by the patient (e.g. co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered. _____ (patient's initials)

Co-pays and deductibles – All co-pays are due at time services are rendered. Deductibles are due upon receipt of an explanation of benefits from your insurance carrier. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please be sure to pay all co-pays and deductibles as stated above. _____ (patient's initials)

Non-covered services – Please be aware that some – and perhaps all – of the services you receive may be a non-covered benefit. You must pay for these services at the time services are rendered. Please note, a check of eligibility is not a guarantee of payment on your behalf from your insurance carrier. _____ (patient's initials)

Coverage changes – It is your responsibility to notify our office immediately upon changes with your insurance carrier. Failure to do so will result in Paloma Medical Group billing you for services rendered. _____ (patient's initials)

Nonpayment – All payments are due immediately and in full. Failure to do so within 90 days will result in your account being sent to an outside collection agency. _____ (patient's initials)

Our practice is committed to providing you with the best treatment possible. We are willing to work with any patient requesting a financial payment plan.

By signing below, you are acknowledging you have read and understand all terms that are outlined I this policy. Should you have any questions or concerns, please feel free to address them with us.

Signature: _____ Date: _____

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Paloma MEDICAL GROUP

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Paloma Medical Group. When you schedule an appointment with Paloma Medical Group, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A "no show" is someone who misses an appointment without canceling it within a 24-hour working days in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

How To Cancel Your Appointment If it is necessary to cancel your scheduled appointment, we require that you call one working day in advance. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel an appointment, please call our office 8:30 am through 4:30 pm at (949) 443-4303, press option 1 then option 1 to speak with a receptionist.

- **Effective January 1, 2018 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50.00 fee. The fee is charged to the patient, not the insurance company.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

(Signature Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Print Name **Date**

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Paloma MEDICAL GROUP

Prescription Refill Policy

As of January 1, 2017, we have a new prescription refill policy. We understand that this is a change for both you and us. We hope to work together to ensure safe and high-quality medical care. Our new policy will be to call in appropriate requests for prescription refills within 7 business days. Plan Ahead! Contact your pharmacy or our office 7 business days before your medication is due to run out.

1. We do require follow up visits every three months for all of our patients taking opioid medications and/or other controlled substances including certain cough syrups. These medications include but are not limited to morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), hydromorphone (Dilaudid), hydrocodone (e.g. Vicodin, Lortab, Norco), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinal), etc. Its patient's responsibility to schedule a follow up visit every three months to avoid delays in getting prescriptions refilled.

2. As part of our new policy, we offer the following options for prescription refills:

    - We can send most prescriptions electronically to local pharmacies.
    - We can send prescriptions electronically to a mail-order pharmacy. You need to have an account set up with the mail-order pharmacy for us to do this.
    - We will no longer mail prescriptions to patient's home (within 25-mile radius), local pharmacies or mail order pharmacies. The patient or an immediate family member designated by the patient must pick up the prescription. We cannot give a controlled substance prescription to any other individual without written permission from the patient. Any individual picking up the prescription on behalf of the patient will be required to show some form of photo ID.

_____ _____

(Signature Parent/Legal Guardian) **Relationship to Patient**

_____ _____

Print Name **Date**

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Paloma MEDICAL GROUP

ADVANCE MEDICAL DIRECTIVES

Definition: Advance Directives can protect your right to refuse or accept medical care if you ever become mentally or physically unable to choose or communicate your wishes due to an illness or injury.

Why have an "Advance Directive"?

This protects your right to make medical decisions that can affect your life. It helps your family by allowing them to avoid the responsibility and stress of making difficult decisions. It helps your doctor by giving them guidelines for your care.

What kind of situation might cause me to need an "Advance Directive"?

If you ever:

- Have irreversible brain damage or brain disease, which can affect you ability to think as well as communicate.
- Have a permanent coma or other unconscious state, which can leave you without hope of recovery.
- Have a terminal illness in which you are expected to die within a short period of time.

What kinds of things can "Advance Directive" discuss?

1. CPR – A procedure is used to restore stopped breathing or heartbeat.
2. IV therapy (intravenous) – This is used to provide food, water, and/or medication through a tube placed in a vein.
3. Feeding tubes – Are inserted through the nose, throat or through a hole in the abdomen (stomach wall) to provide liquid food/nutrition when you cannot eat, chew or swallow yourself.
4. Respirators – are machine used to keep a patient breathing they are unable to breath on their own (previous called "iron lungs")
5. Dialysis – a method of cleansing the blood by a machine when kidneys are no longer working properly.

Advance Directives allow you to state whether you choose any of these procedures or wish to refuse them.

How do I get an "Advance Directive"?

You can make a "living will" or a durable power of attorney for healthcare. You can contact a lawyer to get one of these forms, or you can simply push your wishes in writing; be as specific as possible, then sign the document and have it witnessed and notarized.

Give a copy of your advance directive to your doctor as part of your medical records, and inform your family that you have done so. You can also make special requests or statements such as regarding organ donation, etc

Where can I get more information or help in preparing "Advance Directives"?

- Any family lawyer or attorney
- The state Attorney General's office
- The internet @ http://www.echonyc.com/choice
- Local hospitals
- Local hospice agencies
- Local home health agencies
- Long term care facilities, such as local nursing homes

Please PRINT your name: _____ (Acknowledge that you have read the above)

Signature: _____ Date: _____