Danville Sports Medicine and Primary Care

Danville Sports Medicine and Primary Care's policy for new patients is to do a new patient consultation on the first visit. This is not a complete physical. It includes documenting your past medical history, surgical history, medications, allergies, family and social history. Acute complaints are addressed, and preparations are made for the annual exam. For example, lab slips may be given.

Annual exams happen once a year. For insurance companies and Medicare, these are considered WELL visits. However as a courtesy, and in consideration of patient satisfaction, Dr. Hudson attempts to address ongoing illnesses and new complaints, in as much as time allows.

Please address any concerns you may have about this policy or your health at the onset of the visit, so that proper time may be allocated.

Thank you for your cooperation,

Lisa A. Hudson, MD

I hereby acknowledge that I have read and understood the new patient policy.

Patient Name:____ Date:_________________

Patient/Guardian Signature:____

Danville Sports Medicine and Primary Care

NEW PATIENT REGISTRATION

Date: ______________________ Social Security Number ___________ - ________- ___________

Email Address ____

Pharmacy_____________________________________

Patient's Name: ____
Last Name First MI

Date of Birth: _______________ Male Female Marital Status: S M W D Age _________

Race:____________________ Are you Hispanic? __Yes __No

Language:____________________________ Religion:_________________________/or Declines to specify

Street Address: ____ City:____________________________________

State/zip code: _______________________________________ Home Phone #: (_______) ___________ -- ___________

Cell Phone #: (_______) ___________ -- _____________ Please check box for preferred contact: Home Cell

Ok to leave message on preferred contact? Yes No

Patient's Employer: __________________________________ Work Phone #: (_______) ___________ -- __________

PATIENT'S INSURANCE INFORMATION

Are you the Insurance Subscriber? Yes No (If yes, skip to next section)

If no, who do you receive your insurance through? Spouse Parent Other__________________________

Insurance Subscriber DOB: _________________________ Male Female

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact: ____

Phone #: (_______) __________ -- ___________ Relationship to Patient: __________________________________

Danville Sports Medicine and Primary Care

DATE:____________________

NAME:____________________

DOB:____________________

PATIENT HISTORY FORM

PAST MEDICAL HISTORY

Please check whether you have or have had any of the following conditions:

_____ Acid Reflux
_____ Anemia
_____ Anxiety
_____ Arthritis
_____ Asthma
_____ Bleeding Disorder
_____ Blood Clots/Embolus
_____ Cancer
Type: ________________
_____Colon Polyps
_____COPD

_____ Depression
_____ Diabetes
_____ Emphysema
_____ Epilepsy
_____ Hay Fever
_____ Headaches
_____ Heart Disease/Heart Attack
_____ Heart Failure
_____ Hepatitis
_____ High Blood Pressure
_____ High Cholesterol

_____ HIV
_____ Kidney Disease
_____ Liver Disease
_____ Lung Disease
_____ Stroke
_____ Thyroid Problems
_____ Ulcers

OTHER: ____

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drug allergies:

Drug	Reaction

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

NAME ____ DOB ____________________________

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY		
Alcohol Use	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	☐ Beer ☐ Wine ☐ Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐ Yes ☐ No ☐ Former Smoker If yes, how many cigarettes/packs per day?	
	How many years did you smoke?	What year did you quit?
	Do you chew tobacco? ☐ Yes ☐ No ☐ Former user	How often?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Intake	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups?____________ How many sodas? ____________	

Are you currently employed? ☐ Yes ☐ No

Do you live alone: ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

Have you give Durable Power of Attorney to anyone? If so, please provide their name and phone number:

____

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HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physician and staff and certain participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information. * Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information. *
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse: ____**
☐ **OK to ALL family members: Please list names of family members:**
____

☐ **OK to Other: ____**
☐ **OK to leave health information on answering machine or voice mail**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**
☐ **DO NOT RELEASE TO__________________________**

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:____ Date:___________________

Patient's Name:____________________________________ Date of Birth:____________

If person signing is not patient please provide:

Name:____

Relationship to patient: ____

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BILLING AND FINANCIAL POLICY

The following sets forth the policies of Danville Sports Medicine and Primary Care. Please review this information and sign where indicated below.

- I understand that it is my responsibility to furnish Danville Sports Medicine and Primary Care with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered.

- I understand that Danville Sports Medicine and Primary care is not a provider for any **HMO** insurances unless it is through John Muir Health.

- We are not **Medi-Cal** providers. You will be responsible for all charges if you elect to see our physician.

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. DVSM and/or its representatives will make every effort to assist you but DVSM will not be held accountable for understanding every insurance plan.

- I understand that there is a $30.00 fee to obtain a complete copy of my medical records associated with Danville Sports Medicine and Primary Care.

- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as “Final Notice” and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

- I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

- We request that at least 24-hour notice be given when cancelling or rescheduling an appointment.

- A **$25.00 NO SHOW** fee will be charged to any patient who fails to show for a standard appointment. A **$50.00 NO SHOW** fee will be charged for all physicals and extended visits where a patients fails to show or the appointment is not cancelled at least 24 hours in advance.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to Danville Sports Medicine and Primary Care.

______________________________ ______________

Patient Signature Date