Chino Hills Family Medical Group

Patient Registration Form

Patient Personal Information	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female
Last Name:	First Name: Middle Initial:
Date of Birth: / /	Social Security #: - -
Home Phone ( )	Work Phone: ( ) Cell: ( )
Address:	Apt #: City: State: Zip:
Patient/Responsible Party Information	Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Last Name:	First Name: Middle Initial:
Date of Birth: / /	Social Security #: - -
Home Phone ( )	Work Phone: ( ) Cell: ( )
Address:	Apt #: City: State: Zip:
Patient Insurance Information	*Please present insurance cards to receptionist.*
Primary Insurance Name:	Policy #: Group #
Address:	City: State: Zip:
Name of Insured:	Date of Birth: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Secondary Insurance Name:	Policy #: Group #
Address:	Apt #: City: State: Zip:
Name of Insured:	Date of Birth: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:
Patient Portal	The patient portal is a secured tool for sending and receiving messages with the practice. By providing your email address, you agree to activating your Patient Portal.
Do you wish to activate your patient portal? ☐ NO ☐ YES If YES, please provide email address:	
Preferred Pharmacy	
Name:	
Address:	City: State: Zip:
Emergency Contact	
Name:	Relationship:
Address:	Apt #: City: State: Zip:
Home Phone ( )	Work Phone: ( ) Cell: ( )
Additional Information	
Race:	Ethnicity: Preferred Language: Decline to Answer
If over the age of 18, do you have an Advance Directive? ☐ YES	☐ NO, please provide me with one. ☐ NO, I do not require one at this time.

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Chino Hills Family Medical Group and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date:_____ Signature:_____

Office Policies

Insurance Authorization

_____(Initial) I hereby authorize Chino Hills Family Medical Group to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical benefits, to be paid directly to Chino Hills Family Medical Group. **I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance, such as copayments, deductibles, and coinsurance.**

Check In/Appointment Times

_____(Intial) I understand that it is my responsibility to arrive on-time (at least 20 minutes early if I am a new patient) to my appointment. I understand that if I am a new patient and I arrive 5 minutes after my appointment time (or 10 minutes if I am an existing patient) that I will be rescheduled as accommodating late patients is a leading reason for extended wait times for the patients.

Payment

_____(Initial) I understand that copays and cash services are expected to be paid at the time that the service is rendered. Balances not paid by my insurance company will be expected upon determination of covered benefits. Payments not paid within 90 days will be subject to collection for an additional fee at my responsibility.

Identification

_____(Initial) I understand that in order to be seen in the office, I must provide a valid form of photo identification. I acknowledge that this policy is an effort of Chino Hills Family Medical Group to protect me and all patients from identity theft and that no exceptions will be made. I accept that it is at the discretion of the management to determine if any provided form of identification is "valid".

No Show Policy

_____(Initial) I understand that a missed appointment leaves an empty slot that could have been used for a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. If I am not able to keep my scheduled appointment, I must notify Chino Hills Family Medical Group at least 4 hours in advance, so the time might be available to someone else. A missed appointment, or "no show', occurs when any patient fails to give notice that the appointment cannot be kept. I understand that if I miss appointments without giving the required notice I could be subject to a $25 missed appointment fee.

Prescriptions

_____(Initial) I understand that all prescription refills should be requested through my pharmacy during business hours when my medical record is available to my healthcare provider. I understand that I must allow 2-3 business days for a response and that it is my responsibility not to wait until I am completely out of medication before requesting a refill. I acknowledge that antibiotics and controlled substances (narcotic pain medications, anxiolytic sedatives, ADD/ADHD medications, etc) require an office visit with examination to be refilled, and that providing these medications without a visit is at the discretion of my healthcare provider on a case by case basis. **I acknowledge that refills for pain medications will NOT be given after hours, on weekends or holidays.**

Form Fees

_____(Initial) I understand that there are no fees charged for routine completion of forms. I further acknowledge that all forms require up to 10 days to complete. I understand that it is my responsibility to complete my portion of any forms prior to dropping the forms off and that failing to complete or sign the forms could result in a delay in their completion. I further acknowledge that the 10 days does not begin until I have completed my portion of any forms and dropped them off. I understand that if I require the forms to be completed immediately, there will be a $25 fee for expedited service as the provider will have to stop all other work in progress to complete them.

We know that you have many choices for your medical care and appreciate you entrusting us to provide your medical services. We reserve the right to refuse service to anyone.

I have read this information and understand and agree to the policies of Chino Hills Family Medical Group.

_____ _____ _____

Patient/Parent/Guardian Signature Patient Name Date

HIPAA CONSENT FORM

Chino Hills Family Medical Group

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Chino Hills Family Medical Group** to use and disclose protected health information **(PHI)** about me to carry out treatment, payment and health care operations **(TPO)**.

(The Notice of Privacy Practices provided by **Chino Hills Family Medical Group** describes such uses and disclosures more completely). I have the right to review the Notices of Privacy Practices prior to signing this consent. **Chino Hills Family Medical Group** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Chino Hills Family Medical Group
Attn: Privacy Officer
15631 Central Ave
Chino, Ca 91710

With this consent, **Chino Hills Family Medical Group** may call my home or alternative location and leave a message or voice mail or in person referencing any items that assist the practice in carrying out **TPO**. With this consent, **Chino hills Family Medical Group** may mail or email to my home or alternate location any items that assist the practice in carrying out TPO.

I have the right to request that **Chino Hills Family Medical Group** restrict how it uses or discloses my **PHI** to carry out **TPO.** This practice is required to agree to my requested restrictions and is bound by this agreement.

_____**(Initial)** With this consent, **Chino Hills Family Medical Group** may access my prescription history through medical insurance claims to verify medication names, dosing and quantities to carry out **TPO.**

I allow **Chino Hills Family Medical Group** to release my specifically listed **PHI to**

_____
Name and Relationship of person(s) authorized to receive my PHI

The person(s) named above is/are **ONLY** authorized to inquire and receive PHI, pertaining to the following:

- ☐ ALL PHI
- ☐ Other: _____
  (Specify)

This consent expires on: _____
(List specific date or write" Does Not Expire")

By signing this form, I am consenting to allow **Chino Hills Family Medical Group** to use and disclose my **PHI** to carry out **TPO.** I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Chino Hills Family Medical** may decline to provide treatment to me.

_____
Signature of Patient/Parent/Legal Guardian

_____ Date _____
Print Name of Patient or Legal Guardian

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Chino Hills Family Medical Group

15361 Central Ave., Chino, CA 91710
909 393-7171/Fax 909 393-7676
chfmg@chfmg.com

You may receive a bill from a laboratory for any tests or imaging conducted outside of this office. **Please be advised that any laboratory/radiology fees, and or bills that you receive are your responsibility.**

If your insurance does not cover particular laboratory tests, images, or requires that you use a specific laboratory for such procedures, **it is your responsibility to inform this office. Please contact your insurance carrier if you do not know what is covered by your policy.**

I have read and acknowledge receipt of this notice.

_____ _____

Patient of Guarantor Signature Date

_____

Print Name of Patient or Guarantor