New Patient Registration Form

Today's Date		Please print				
PATIENT INFORMATION						
Full legal name	First	Middle	Last	Name Normally Used (Nickname)		
Physical Address (where you live)			Apt. No.	City	State	Zip
Mailing Address			Apt. No.	City	State	Zip
Email	Home Phone		Work Phone	Cell Phone		
Social Security No.	Sex		Date of Birth	Driver's License No.	State Issued	
Employer Name	Employer City		Employer State	How did you hear about us?		
List anyone you authorize this office to share your medical information with (**name & relationship to you**):						
Permitted Contact Method(s) (circle all that apply): Home phone Cell phone Work phone Mail Email				Okay to leave message on answering machine/voicemail? Yes ____ No _____		
Do you require an interpreter? Yes ____ No _____						
SPOUSE'S INFORMATION						
Full legal name	First	Middle	Last	Home Phone		
Occupation	Employer Name		Work Phone	Cell Phone		
INSURANCE INFORMATION						
Primary Insurance Company Name			Group No.	ID/Certificate No.		
Policy Holder's Name/Parent's Name (if patient a child) **D.O.B.**			Policy Holder's Social Security No.			
Secondary Insurance Company Name			Group. No.	ID/Certificate No.		
Policy Holder's Name						
EMERGENCY INFORMATION						
Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone			

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.

2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans require a copayment at the time of service. If copay was not paid at time of service a $10 fee will be applied. Most contract health plans require that the claim be submitted by our office.

We request payment at the time of service. We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card. If you are responsible for a co-pay/deductible we require that your portion be paid at the time of service. We will make every effort to provide you with the accurate amount due at the end of your visit today. However, your medical and billing records will be reviewed within 1-2 days of your visit. If there are any discrepancies in the coding and billing, you will receive an additional bill or a refund if overcharged.

I hereby authorize the release of any medical information to insurance carriers needed to process a claim and request payment be sent to AriaMed for medical services rendered. I authorize AriaMed to release any medical records for referral purposes if need be. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days.

Patient/Guardian Signature:	Relationship:	Date:

ARIA

Record #: _____

Patient Intake Form

Patient's Full Name: _____ **Age:** _____ **Date:** _____

Ethnicity: _____ **Preferred language:** _____

1. Primary care physician you were seeing previously: _____

2. Are you currently a patient of theirs still? Yes ____ No _____

3. Other physicians you are/were seeing: _____

_____

4. Allergies to any medications (including reaction): _____

5. All **current prescription medicines** (including dosage, reason you take it, who prescribed it): _____

_____

_____

_____

6. All **over-the-counter medicine**, vitamins, and food supplements that you take: _____

_____

7. Have you had any of the following problems?

☐ bleeding problem	☐ migraines	☐ hepatitis	☐ mono	☐ ulcer
☐ tuberculosis	☐ blood clots	☐ head injury	☐ drug addiction	☐ gallstones
☐ high blood pressure	☐ STDs	☐ seizures	☐ memory trouble	☐ thyroid disease
☐ cancer	☐ heart murmur	☐ anxiety	☐ gout	☐ hemorrhoids
☐ heart disease	☐ depression	☐ hearing trouble	☐ asthma	☐ stomach problems
☐ diabetes	☐ vision problems	☐ glaucoma	☐ heart attack	☐ skin problems

List any other important health problems that you have been experiencing: _____

_____

_____

8. Who in your *family* has/had (**if problem was cause of death, please write age of death**):

Alcoholism _____	Diabetes _____	Heart disease _____	Stomach problems ____
Allergies _____	Drug addiction _____	High blood pressure ___	Thyroid disease _____
Asthma _____	Genetic disorder _____	Memory loss _____	Tuberculosis _____
Cancer _____	Headaches _____	Mental illness _____	Vision problems _____

List any other diseases that run in your family and specify your relationship to each family member listed: _____

_____

9. Marital status? (circle) Single Married Divorced Separated Long-term relationship Widow(er)

Who lives with you? _____

Do you have any children? If yes, list their name(s) and age(s) _____
Yes ____ No ____ _____

Where do/did you work? _____ What line of work are you in? _____

What is the last grade in school you finished? _____

10. Habits: _____

Do/did you use tobacco? Type of tobacco use (circle): Cigarettes E-cigarettes Cigars Smokeless
Yes ____ No ____

If so, how many packs/cigars/cans per day? _____

When was the last time you tried to quit? _____ How many times have you tried to quit? _____

Do/did you DRINK alcohol? If so, drinks/day? _____ # of years: _____ Year you QUIT: _____
Yes ____ No ____

Previous or current problem with alcohol? **Yes ____ No ____**

Do/did you use drugs?
Yes ____ No ____ If yes, which one(s)? _____

Do you have a history of prescription drug abuse or addiction? If yes, which one(s)? _____
Yes ____ No _____

How much caffeine do you drink per day? _____

How often do you exercise? _____ hrs/week Type of exercise: _____

Are you sexually active? Yes ____ No ____ With whom? MEN WOMEN BOTH

What is your diet like? _____

_____

11. **Surgeries** you have had (include year, surgeon, and hospital): _____

_____

12. **Hospitalizations/illnesses** not included above (include year, hospital): _____

_____

PREVIOUS VACCINES & TESTS

Name	Tetanus/Tdap	Hepatitis A/B	Hib	HPV	Influenza	MMR	Meningococcal
Date							
Name	Pneumonia	Polio	Varicella	Zoster	TB Test	Chest X-Ray	Colonoscopy
Date							

DO YOU HAVE ANY OF THE FOLLOWING? (circle all that apply)

Living Will	Advanced Directives	POLST (Physician Order for Life Sustaining Treatment)

I would like more information about the documents above. Yes ____ No __

Women

Age at first period: _____ Date of last normal period: _____ # of pregnancies:_____

# of live births: _____ # of children living with you: _____ # of abortions/miscarriages: _____

Year(s) born: _____ Vaginal or Cesarean delivery? _____ Complications? _____

Problems with pregnancies (circle): Pre-term labor Toxemia Diabetes High blood pressure

Other: _____

Birth control method: _____

Date of last Pap: _____ Result? _____ Done where? _____

Date of last mammogram? _____ Result? _____ Done where? _____

Do you have (circle):

Irregular periods	Bad menstrual cramps	Heavy periods	Abnormal mammogram	Abnormal Pap smear
pelvic pain	infertility	sexual difficulty	hot flashes	vaginal dryness
vaginal discharge	vaginal odor	vaginal itching	PMS	breast changes

Patient Responsibilities

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate as "patient responsibility". Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure or diagnosis codes. We are unable to make a change once the insurance has been billed.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

We may charge an upfront **$50.00 administrative fee** for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a **25% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a **$45.00 service fee** in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. **AriaMed also reserve the right to charge a no-show fee for patients who miss appointments *without* calling to cancel within 24 hours of the appointment.** The current **no-show fee is $25.00** and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES.
I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Rights Regarding Medical Records**
- **Patient Responsibilities including collections & no-show policy**
- **Confidentiality and Privacy of Medical Records**

_____ _____

Patient/Guardian Signature Date

_____

Patient Printed Name

Authorization to Release Medical Information

Release to:
AriaMed

10 Harris Ct, Suite A2, Monterey, CA 93940
515 Alameda Ave, Suite D, Salinas, CA 93901

831.900.5115

1. Information to be released (check all that apply):

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-Ray Reports
☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other: _____

SPECIAL AUTHORIZATION
Check applicable box(es) and sign immediately below

By signing below, I am authorizing the office to release any and all information regarding:

Alcohol **Drugs** **Mental Health** **Sexually Transmitted Diseases** **HIV** **AIDS**

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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

2. Records from the time period: _____/_____/_____ through _____/_____/_____

3. Purpose of disclosure (check all that apply):

☐ Continued Medical Care ☐ Payment of Insurance Claim ☐ Legal
☐ Personal ☐ Workers' Compensation Claim ☐ Other: _____

4. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

5. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

6. The requester may be provided with a copy of this authorization.

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Patient/Guardian Signature: _____ Date: _____

For office use only:

MR #: _____ Date: _____ Initials of Staff Sending: _____

Patient Rights Regarding Medical Records

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing on the proper forms which will be provided upon request. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member.

Changes to This Notice
We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission for any health information that has not yet been shared.

_____	_____	_____
Patient/Guardian Signature	Patient/Guardian Printed Name	Date

Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information
The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI
The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment..

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

_____	_____	_____
Patient/Guardian Signature	Patient/Guardian Printed Name	Date