FOLSOM INTERNAL
MEDICINE ASSOCIATES

PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

Nick Name:_____ DOB:_____ Gender:_____ Marital Status:_____

Primary Phone:_____-_____-_____Secondary Phone:_____-_____-_____SSN: _____-_____-_____

Mailing Address:_____ City:_____ State:_____ Zipcode: _____

Physical Address:_____ City:_____ State:_____ Zipcode:_____

Emergency Contact:_____ Primary Phone:_____-_____-_____ Relation:_____

Emergency Contact:_____ Primary Phone:_____-_____-_____ Relation:_____

Imaging Facility:_____ City:_____ Phone: _____-_____-_____

Laboratory Name:_____ City:_____ Phone: _____-_____-_____

Pharmacy Name:_____ City:_____ Phone: _____-_____-_____

Insurance:_____ ID#:_____ Group: _____

Policy Holder Name:_____ DOB: _____ Relation:_____

Email Address: _____Preferred Method of Contact: _____

LEGAL GUARDIAN/ GUARANTOR INFORMATION

Last Name:_____ First Name:_____ M.I._____

Nick Name:_____ DOB:_____ Gender:_____ Marital Status:_____

Primary Phone:_____-_____-_____Secondary Phone:_____-_____-_____Relation:_____

Mailing Address:_____ City:_____ State:_____ Zipcode: _____

Physical Address:_____ City:_____ State:_____ Zipcode:_____

Next of Kin:_____ Primary Phone:_____-_____-_____ Relation:_____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Folsom Internal Medicine, Inc.

Bre Howard, Privacy Officer

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning patient:

Patient Last Name: _____

Patient First Name: _____

This health information may be disclosed to:

(include last name, first name, and relationship to patient)

_____

_____

_____

_____

_____

Please mark the type of records that may be disclosed:

_____ Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below

_____All psychotherapy notes may be released, except as specifically provided below:

_____Claims/Billing Records

_____Other:_____

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"):_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.
I understand that if I do not sign this form:
A health plan may not enroll me or make me eligible for benefits.
My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which would otherwise be performed solely for the purpose of disclosure to a third party.

The authorization is in effect and will remain in effect until: _____
I understand that I have a right to received a copy of this authorization upon request.

Signature: _____ ***Date:*** _____

Legal Guardian/Guarantor Full Name: _____

*If not signed by the patient please indicate the relationship :*_____

Patient Health Information

MEDICATIONS:
(list all prescribed or over the counter medications, supplements, or vitamins taken regularly or semi-regaularly)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES:
(list all drug, food, and environmental)

_____

_____

MEDICAL HISTORY:
(circle all current and past medical problems)

Anemia	Cancer	Heart disease	Liver disease
Anxiety Disorder	Coronary Artery Disease	Hepatitis	Pulmonary Embolism
Arthritis	Deep Vein Thrombosis	High Cholesterol	Reflux/GERD
Asthma	Depression	Hypertension	Seizures/Epilepsy
Autoimmune disease	Diabetes	Hyperthyroidism	Stroke
Bleeding disorder	Diverticulitis	Hypothyroidism	Tuberculosis
Bronchitis	Gout	Kidney disease	Breast cancer
COPD	Headaches	Kidney stones	Rectal Bleeding

Other: _____

SURGICAL HISTORY

(Please list all surgeries and the date of service)

_____

_____

_____

_____

FAMILY HISTORY

(List history of the following conditions. Include relationship i.e. maternal grandmother, paternal grandmother)

Cancer: _____

Diabetes: _____

Heart Disease/Problems: _____

Bleeding Problems: _____

Respiratory Problems: _____

Problems with Anesthesia:_____

SOCIAL HISTORY

Smoking Status: _____Smoking how much? _____ Tobacco years of use: _____

Able to care for self?: _____ Live alone or with others? _____ Do you have an Advance Directive?: _____

Are you currently employed?:_____ Occupation: _____

Education: _____ General stress level: _____

Number of children: _____ Guns present in home?: _____ Alcohol intake: _____

Caffeine intake: _____ Illicit drugs: _____

Diet: _____ Exercise level: _____ Hard of hearing or deaf?: _____

Legally blind in one or both eyes?: _____ Sexually Active?:_____ Do you use protection?: _____

Sexual orientation: _____ Smoke alarm in home: _____ Has smoked since age: _____

Passive smoke exposure: _____ Chewing tobacco: _____ Seat belts used?: _____ Sunscreen?: _____

Swimming/diving: _____ Can child swim?:_____ Is the patient ambulatory?: _____

Last Physical Exam: _____ Last PAP: _____ Last Tetanus: _____ Last Colonoscopy: _____

MRN _____

PATIENT FINANCIAL PARTNERSHIP POLICY

(Version 1.0)

To Our Patients:

We are pleased that you have chosen *Folsom Internal Medicine Associates* to provide your medical services. We are committed to providing you with the best possible medical care to meet your needs. Our practice firmly believes we must maintain a high level of understanding and good communication with our patients throughout their care. We pride ourselves on communicating with you any anticipated out-of-pocket costs to create a better understanding and level of expectation. Our Patient Financial Partnership Policy is designed to be completely transparent to avoid any surprises during your medical care.

The following information is provided to clarify our policies about the financial portion of your medical care:

1. **Time of Collection:** We collect copayments, outstanding balance payments, and costs of service (self-pay), when you check in for your appointment with our front desk staff. You must present a current insurance card at each visit.
   - If you do not present a current insurance card or we are unable to confirm your insurance eligibility you may be responsible for payment at the time of your visit. You will receive reimbursement from *Folsom Internal Medicine Associates* if your insurance pays the claim at a later date. Your co-payment may be adjusted after the time of service depending upon the final payment decision from your health insurance plan.
   - Patients being seen without insurance coverage are required to pay the cost of service upon arrival.

2. **Financial Policy:** Patients are responsible for: payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by your insurance plan. If payment from your insurance company is not received within 60 days from date of service, you may be expected to pay the balance in full. The only exception to this is an approved workers compensation claim. If your workers compensation status is reversed, you will be expected to pay the balance in full.
   - Our office accepts many forms of payment: cash, personal checks, MasterCard, Visa, Discover, and American Express. We do not accept ATM only cards (cards without a Visa or MasterCard logo). All personal checks with be electronically debited from your account the day of service. Returned checks will be subject to collection fees.

3. **Account Balances:** Financial estimates are not always exact. Account balances reflect the final service(s) rendered and insurance benefits allowed under your chosen plan. For patients experiencing financial hardships, cases will be reviewed on an individual basis and may be subject to application of our Payment Plan Policy. Past due accounts will affect your ability to have appointments scheduled.

4. **Missed Appointment Policy:** If you must cancel an appointment, *Folsom Internal Medicine Associates* requires a minimum of 24-hours notice. All appointments missed without notice are subject to a $50.00 no-show fee. Missed appointments represent a cost to us, to you, and other patients who could have been seen in the time set aside for you.

If you decide you can't or won't meet these guidelines we may need to reschedule any future appointments or services until a time when you are able to do so. Any account balance that remains after efforts to collect payment by our Billing department could be transferred to a 3rd party collection partner. *Please note a situation of this type would be considered on a case-by-case basis.

It is extremely important that we be notified of any changes in your insurance status or your insurance carrier. This includes: eligibility changes, becoming newly insured or uninsured, acquiring additional or new secondary coverage. ***It is also important*** that we have your correct address information on file. Please notify us if there is a change to your address, telephone, or other contact information. If you do not update us with your information we will not be able to bill your insurance. This could result in a direct balance billing to you.

Folsom Internal Medicine Associates understands that there are many reasons why you may be seeking out care from our facility. We hope to help you as much as possible through this process and be an advocate for you as you navigate through the financial portion of your medical care.

MRN _____

Patient Financial Partnership Policy

By signing below, you certify that you have received, read, and understand *Folsom Internal Medicine Associates* Patient Financial Partnership Policy. **(Version 1.0)**

I understand that FIMA *may, at its discretion, change the terms and conditions of their policies. I understand that I may request a copy of* Patient Financial Partnership Policy *at any time.*

Printed Name of Patient: _____

Signature: _____ **Date:** _____

Authorization to Pay for Professional Services Rendered:

I hereby authorize payment directly to FIMA of the benefits for professional services rendered, otherwise payable to me as determined by my insurance company, but not to exceed the fee as finally determined by my provider. I understand that I am financially responsible for any professional charges not paid by my insurance company to FIMA.

I understand FIMA's Professional Services Rendered Policy.

Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices:

I hereby acknowledge I have received a copy of the Notice of Privacy Practices for FIMA. I understand that FIMA may, at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request.

Signature: _____ **Date:** _____

Consent to Treatment:

I consent to general treatment, medical procedures, and medications prescribed by FIMA.

Signature: _____ **Date:** _____