HERITAGE
VICTOR VALLEY MEDICAL GROUP

PATIENT REGISTRATION FORM

Date_____

Patient's Full
Name_____
(Last) (First) (Middle) (Maiden)

Date of Birth_____Social Security#_____Marital Status: S M W D
Address_____
City_____ State_____ ___Zip Code_____
Home Phone_____Cell Phone_____Other Phone_____
Email Address_____
Employer_____Phone_____
Address_____
Spouse's Name_____Date of Birth_____Social Sec#_____
Employer_____Phone_____
Emergency
Contact_____Home#_____Work#_____
(THIS MUST BE COMPLETED)

Complete below for patients under 18 and/or covered by the parents insurance

Father's Full Name_____Date of Birth_____SS#_____
Address (if different from child)_____
City_____State_____ Zip Code_____
Home
Number_____Employer_____Phone_____

Mother's Full Name_____Date of Birth_____SS#_____
Address (if different from child)_____
City_____State_____ Zip Code_____
Home
Number_____Employer_____Phone_____

How did you hear about us? (Please check all that apply)

Insurance_____Work_____Website_____Patient_____Radio_____Mailer_____
Family_____Hospital_____Physician_____Friend_____Newspaper_____Yellow Pages_____

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INSURANCE INFORMATION

COMPLETE ONLY IF YOU **DO NOT** HAVE A CURRENT COPY OF YOUR INSURANCE CARD, BE SURE TO NOTIFY US IF YOUR INSURANCE HAS CHANGED.

Primary Insurance_____Effective Date_____
Member's Name (Policy holder)_____Policy Holder's Date of Birth_____
Policy Holder's Social Security#_____
Member ID#_____Group#_____Employer_____
Secondary Insurance_____Effective Date_____
Member's Name (policy holder)_____Policy Holder's Date of Birth_____
Policy Holder's Social Security#_____Member ID #_____
Group #_____Employer_____

Assignment and release

I, the undersigned, assign directly to Heritage Victor Valley Medical Group (HVVMG)/High Desert Medical Group (HDMG) all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the office to release all information to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

I further authorize Heritage Victor Valley Medical Group (HVVMG)/High Desert Medical Group (HDMG) to disclose information in my medical records, including current and previous medical records, to other physicians and health care providers to whom the physician refers me for my treatment.

Financial Agreement

I acknowledge that payment is due at time of service and I agree that parent/Guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges not covered by insurance.

Signature_____Date_____
Witness _____Relationship to patient_____

Minor Child Consent

I, being the parent/guardian of _____do hereby request and authorize Heritage Victor Valley Medical Group (HVVMG)/High Desert Medical Group (HDMG) and staff to perform necessary services for my child, including but not limited to x-rays, labs and administration of medications and anesthetics which are deemed advisable by the physician.

Signature_____Date_____

Witness_____Relationship to patient_____

PATIENT REGISTRATION FORM

Office Financial Policy

We are happy that you selected Heritage Victor Valley Medical Group (HVVMG) for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.
Patients are financially responsible for all services provided and are expected to pay for services received on the same date services are rendered. Patients are also responsible for any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship.

Medicare

The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare Part B deductible
- 20% co-pay of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental

The office will bill both Medicare and the secondary insurances.

Medi-Cal (ACCEPTED ONLY WITH MEDICARE AS PRIMARY)

Medi-Cal patients must provide the clinic with a **current Medi-Cal card** with every visit. Medi-Cal patients are responsible for all **non-covered services**. Medi-Cal patients are responsible for securing necessary referrals from the primary care physicians.

HMOs and PPOs

Patients are responsible for payment of the co-pay and the deductible at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary.

Commercial Insurance

Patients are responsible for any **co-pay, deductible, or non-covered amounts. Insurance is billed as a courtesy.** Patients are responsible for the balance in full, if not paid by insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, the nurse (RN/LVN) will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

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Self-Pay

Patients are responsible for payment in full at the time of service for all services rendered.

Personal Injury/Motor Vehicle accidents

The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company will be handled by you, your insurance company, and/or your attorney.

Managed Care

If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patients benefits for out of state or out of network benefits. The patient will either be required to make payment in full or pay any co-pay or deductible.

I understand the above policy and acknowledge that I am financially responsible for all services rendered.

Patient or Parent/Guardian Date

Heritage Victor Valley Medical Group (HVVMG)
12370 Hesperia Rd., Suite 6
Victorville, CA 92395
(760)245-4747
Attention: Compliance Officer
www.hvvmg.com

NOTICE OF PRIVACY PRACTICE

Acknowledgement of receipt of Notice of Privacy Practices

This Notice of Privacy Practice describes how your medical information may be used and disclosed and how you may obtain access to your medical information. Please review this notice carefully.

I acknowledge that I have received a copy of the revised Notice of Privacy Practice:

_____ _____
Signature of: Date

_____ _____
Print Name Date of Birth

[ ] Patient [ ] Patient/Guarantor [ ] POA

I decline a copy of the revised Notice of Privacy Practice:

_____ _____
Signature of: Date

_____ _____
Print Name Date of Birth

[ ] Patient [ ] Patient/Guarantor [ ] POA

Instructions to Receptionist: Provide a copy of the Revised Notice of Privacy Practice to each patient. Forward only the signed signature page to the Health Information Management Department (HIM) to be scanned into the patient's chart.

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REQUEST FOR SPECIAL VERBAL METHOD OF COMMUNICATION

I, _____hereby authorize Heritage Victor Valley Medical Group to leave a message on my voicemail as follows: (Check all that apply):

☐Call for the results (No results will be left on the voicemail)
☐Call regarding referral (ready for pick up/appt. made)
☐Call regarding billing issues_____ Call to
☐make an appt./confirm appt.
other:_____
☐Call caregiver (name) _____Give care instructions
☐Release verbal medical information, confirm appointments, and provide instruction for continuation of medical care (for case management purposes- hospital patients only).

Leave any of the above messages with:

_____
_____ (Name of authorized person)

With the exception of that information which may by protected by federal law and which will require specific authorization from me.

I hereby authorize **Heritage Victor Valley Medical Group** and all of their agents and employees from any liability, harm or loss that may result thereof.

This authorization shall be valid from the date it was signed until revoked in writing.

Note to patient: The health care provider reserves the right to determine at any time whether to release the information as authorized, or ask the patient to return the call to discuss the results.

The patient may revoke this authorization at any time by submitting a request in writing.

_____/_____
Patient's Signature Date

Patient's Name: _____
DOB: _____

Heritage Victor Valley Medical Group
(HVVMG)

NOTICE OF PRIVACY PRACTICE

Your Information. Your Right. Our Responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your rights

When it comes to your health information, you have certain rights.

You have the right to

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct the health record about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we share it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your right and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting out Privacy Officer at Heritage Victor Valley Medical Group, 12370 Hesperia Rd., Suite 6 Victorville, CA 92395, (760) 245-4747, Attention: Compliance Officer
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to the Office for Civil Rights, DHHS., 90 7th Street, Suite 4-100, San Francisco, CA 94103, (415)437-8310; (415)437-8311 (TDD), (415)437-8329 FAX, or visiting WWW.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situation described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information is we believe it is in your best interest. WE may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give is written permission:

- Marketing purposes
- Sale of your information (HVVMG does not sell patient Information)
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from the health plans or other entities.

Example: We give information about you to your health insurance plan, so it will pay for your services.

Help with public health and safety issues

We can share health information about you for certain situation such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations if you are an organ donor.

Work with a medical examiner or funeral director

We can share health information with the coroner, medical examiner, or funeral director when an individual dies.

Address worker's compensation, law enforcement, and other government requests

We can use or share health information about you:

- For worker's compensation claims.
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court order, or in response to a subpoena

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding /consumers/index.html

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless; you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see:

www.hhs.gov/oc/privay/hipaa/understanding/consumer/noticepp.html.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

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Health History Questionnaire

Date:
Date Reviewed:

All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Name(Last, First, M.I.) ☐M ☐F	**DOB:**
Marital Status: ☐Single ☐Partnered ☐Married ☐Separated ☐Divorced ☐Widowed	
Previous or referring Doctor:	**Date of last physical exam:**

Personal Health History

CHILDHOOD ILLNESS: ☐Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐Polio

Immunizations ☐Tetanus ☐Pneumonia

And dates: ☐Hepatitis ☐Chickenpox

☐Influenza ☐MMR (Measles, Mumps, Rubella)

List any medical problems that doctors have diagnosed:

Surgeries

Year	Reason	Hospital

Other Hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐Yes ☐No

Please turn to next page…..

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of Drug	Strength	Frequency taken
Allergies to medications		
Name of Drug	Reaction you had	

HEALTH HABITS AND PERSONAL SAFETY

All QUESTIONS CONTAINED IN THIS QUESTIONAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐Sedentary (No Exercise)					
	☐Mild Exercise(i.e. climb stairs, walk 3 blocks, golf)					
	☐Occasional vigorous exercise (i.e. work or recreation, less than 4x/week/week for 30 mins)					
	☐Regular vigorous exercise (i.e. work or recreation 4x/ week for 30mins)					
Diet	Are you dieting?				☐Yes	☐No
	If yes, are you on a physician prescribed medical diet?				☐Yes	☐No
	Number of meals you eat in an average day?					
	Rank salt intake	☐High	☐Medium	☐Low		
	Rank fat intake	☐High	☐Medium	☐Low		
Caffeine	☐None	☐Coffee	☐Tea	☐Cola		
	#of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐Yes	☐No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐Yes	☐No
	Have you considered stopping?				☐Yes	☐No
	Have you ever experienced blackouts?				☐Yes	☐No
	Are you prone to “binge” drinking?				☐Yes	☐No
	Do you drive after drinking?				☐Yes	☐No
Tobacco	Do you use tobacco?				☐Yes	☐No
	☐Cigarettes – Pks/day	☐Chew - #/day	☐Pipe - #/day	☐Cigars - #/day		
	☐#of years	☐or year quit				
Drugs	Do you currently use recreational or street drugs?				☐Yes	☐No
	Have you ever given yourself street drugs with a needle?				☐Yes	☐No
Sex	Are you sexually active?				☐Yes	☐No
	If yes, are you trying to get pregnant?				☐Yes	☐No
	If not trying for pregnancy, list contraceptive or barrier method used:					

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	Any discomfort during intercourse?	☐Yes	☐No
	Illness related to the Human Immunodeficiency Virus(HIV). Such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected intercourse. Would you like to speak with your provider about your risk of this illness?	☐Yes	☐No
Personal Safety	Do you live alone?	☐Yes	☐No
	Do you have frequent falls?	☐Yes	☐No
	Do you have vision or hearing loss?	☐Yes	☐No
	Do you have an advance directive or living will?	☐Yes	☐No
	Would you like information on the preparation of these?	☐Yes	☐No
	Physical and/or Mental abuse have also become a major public health issue in this country. This often takes place in the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐Yes	☐No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	☐M ☐F	
Mother				☐M ☐F	
Siblings	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		Grandmother Maternal		
	☐M ☐F		Grandfather Maternal		
	☐M ☐F		Grandmother Paternal		
	☐M ☐F		Grandfather Paternal		
Other	☐M ☐F				

MENTAL HEALTH

Is stress a major problem for you?	☐Yes	☐No
Do you feel depressed?	☐Yes	☐No
Do you panic when stressed?	☐Yes	☐No
Do you have problems with eating or your appetite?	☐Yes	☐No
Do you cry frequently?	☐Yes	☐No
Have you ever attempted suicide?	☐Yes	☐No
Have you ever thought about seriously hurting yourself?	☐Yes	☐No
Do you have trouble sleeping?	☐Yes	☐No
Have you ever been to a counselor?	☐Yes	☐No

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WOMEN ONLY		
Age at onset of menstruation		
Date of last menstruation:		
Period every____Days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐Yes	☐No
Number of pregnancies____ Number of live births____		
Are you pregnant or breastfeeding?	☐Yes	☐No
Have you had a D & C, hysterectomy, or cesarean? If yes, list which one and date_____	☐Yes	☐No
Any urinary tract, bladder, or kidney infections within the last year?	☐Yes	☐No
Any blood in your urine?	☐Yes	☐No
Any problems with control of urination?	☐Yes	☐No
Any hot flashes or sweating at night	☐Yes	☐No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the time of your period?	☐Yes	☐No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐Yes	☐No
Date of last pap and rectal exam: Date of last mammogram: **Age 50 & over only** Date of last Colonoscopy:_____ Date of last DEXA scan:_____		

MEN ONLY		
Do you usually get up to urinate during the night?	☐Yes	☐No
If yes, # of times _____		
Do you have pain or burning with urination?	☐Yes	☐No
Any blood in your urine?	☐Yes	☐No
Do you feel burning discharge from your penis?	☐Yes	☐No
Has the force of your urination decreased?	☐Yes	☐No
Have you had any kidney, bladder, or prostate infections within the last 12 months	☐Yes	☐No
Do you have any problems emptying you bladder completely?	☐Yes	☐No
Any difficulty with erections or ejaculation?	☐Yes	☐No
Any testicle pain or swelling?	☐Yes	☐No
Date of last prostate and rectal exam:_____		
Age 50 & over only Date of last colonoscopy:_____		

Other Problems		
Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.		
☐Skin	☐Chest/Heart	Recent Changes in:
☐Head/Neck	☐Back	☐Weight
☐Ears	☐Intestinal	☐Energy Level

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☐Nose	☐Bladder	☐Ability to sleep
☐Throat	☐Bowel	☐Other pain/discomfort
☐Lungs	☐Circulation	

If signed by someone other than the patient, please print the name and relationship to patient:

Print name_____Relationship_____

_____

Print patient name Parent/Guardian Signature Date

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TST RISK ASSESSMENT

Date:_____

☐**All Negative**

High Risk

>=5mm induration is considered positive with risk factors listed below NO YES

1. Is the patient HIV positive? ☐ ☐
2. Has the patient ever had a chest x-ray that was suggestive of TB? ☐ ☐
3. Has the patient had close contact with someone who has infectious TB? ☐ ☐
4. Has the patient had an organ transplant? ☐ ☐
5. Is the patient Immunosuppressed for other reasons? ☐ ☐
   (e.g., taking the equivalent of 15mg of prednisone per day)

Intermediate Risk

>=10mm induration is considered positive with risk factors listed below

1. Does the patient have any chronic medical problems that increase their risk? ☐ ☐
2. Was the patient born in a country where TB is prevalent? ☐ ☐
3. Has the patient traveled outside the US since their last TB test? ☐ ☐
4. Does the patient use or have they ever used IV drugs? ☐ ☐
5. Is the patient working or living in a congregate setting? ☐ ☐
   (e.g., Homeless Shelter, Jail/Prison, or Nursing Home)
6. Is the patient a healthcare worker? ☐ ☐

Low Risk

>=15mm induration is considered positive

Persons with No risk factors for TB

*Although skin testing programs should be conducted only among high risk groups, certain individuals may require TST for employment or school attendance. An approach independent of risk assessment is recommended by the CDC or the American Thoracic Society.

Name _____ **DOB**_____