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

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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)
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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Authorization To Consent To Medical Treatment For A Minor Child

If your child needs medical treatment, you as a parent must give permission. If you cannot be reached immediately, treatment can be given without your permission only in emergent cases. Otherwise, your child cannot be treated until your consent is obtained, which may cause unnecessary delays as well as some anxious moments for your child.

This form allows for the medical treatment of your child if you cannot be reached. Whether you are on vacation or simply shopping, this form is indispensable if you ever place your child in the care of a babysitter, relatives, or friends.

You can be ready for those unexpected emergencies by completing the form below, one for each child. We the undersigned parents/guardians of the following minor child;

_____

Child's Name (Please print clearly) Date of Birth

Do hereby authorize the following person(s) as our agents (Person(s) must be 18yrs of age or older)

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

To consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under general supervision of a duly licensed physician whether such diagnosis or treatment is rendered in the office of said physician or at the hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospitalization being required. It is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable; and neither said agent or any organization involved assumes any financial responsibility for exercising the action.

Date_____Special Medical Information_____
_____
_____Medications_____
_____
_____

Parents/Guardians:_____Doctor_____
(Signature-complete name-DO Not Print)
Address_____Doctor's Phone_____

Home Phone_____Bus#_____

Witness_____

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Child Health Record

History of pregnancy with this child

During which month of pregnancy did you first see the doctor?____months
Where was baby born?_____
How long was your pregnancy?___months
If baby was born at home, were blood tests for newborn done? Y N

Did you have any illness or problems?(including sexually transmitted or communicable diseases?)	Yes	No	Did you use any non-prescription drugs? (tobacco, alcohol, street drugs, over-the –counter, or home remedies)	Yes	No
Did you take any medication prescribed by your doctor?	Yes	No	Did he baby go home with you from the hospital?	Yes	No
Did you have a difficult/abnormal delivery/CSection?	Yes	No	Was more than one baby born?	Yes	No
Did the baby have any problems during the first week of life?	Yes	No	Did the baby receive any shots for hepatitis B?	Yes	No

Child's History: Male Female Is this child adopted? Yes No Birth weight___lbs. ___oz. Length____inches

Recent Travel Yes No Where did you travel?

Has your child ever had:

Measles, Chicken Pox, Mumps, Rubella	Yes	No	Vomiting after eating, refusal to eat	Yes	No
Tuberculosis or Positive TB Test	Yes	No	Muscle, joint, or bone problems	Yes	No
Tonsillitis/Sore throat	Yes	No	Skin problems	Yes	No
Problems with eyes or vision	Yes	No	Headaches or dizziness	Yes	No
Problems with ears or hearing	Yes	No	Convulsions, seizures, or epilepsy	Yes	No
Difficulty breathing/snoring at night	Yes	No	Diabetes	Yes	No
Heart problems	Yes	No	Thyroid problems	Yes	No
Asthma, bronchitis, or pneumonia	Yes	No	Allergies	Yes	No
Anemia, bleeding problems, blood transfusions	Yes	No	Problems with development or school performance	Yes	No
Stomach aches	Yes	No	Serious illness or accident	Yes	No
Diarrhea, soiling self with stool	Yes	No	Surgery or hospitalization	Yes	No
Bladder or kidney problems, wetting self or bed	Yes	No	(Girls) Has she started menstruation	Yes	No
Constipation	Yes	No	(Girls) Are there problems with period	Yes	No
Problems with language deficiencies	Yes	No	Problems with developmental deficiencies	Yes	No

Family History: Does mother(M), father(F), brother(B), sister(S), aunt(A), uncle(U), or grandparents(GP) have/had:

		Which family member?				Which family member?	
Yes	No	Diabetes		Yes	No	High Blood pressure	
Yes	No	Epilepsy or Convulsions		Yes	No	Bleeding disorder	
Yes	No	Mental retardation		Yes	No	Tuberculosis	
Yes	No	Heart disease		Yes	No	Allergy	

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Yes	No	Cancer		Yes	No	Lung or breathing problems	
Yes	No	Kidney or urinary disease		Yes	No	Eye disorder	
Yes	No	Bone or joint problems		Yes	No	Ear Disease	

Parent Information:

	Mother	Father
Age:	_____	_____
Height	_____	_____

Occupation:_____

Number of people in home:_____

Are both parents living in the home? Yes or No

Does anyone in the home smoke or use alcohol? Yes or No

Language spoken in the home:_____

Parent Identification:

Signature:_____

Relationship to child:_____

Reviewer's Signature_____

Date:_____

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Pediatric TB Risk Assessment Questionnaire

Cuestiono para deteminar riesgo de Tuberculosis

Name of child/Nombre Del Paciente:_____

Date of Birth/Fecha de Nacimiento:_____

Today's Date/Fecha: __/__/__ __/__/__ __/__/__ __/__/__ __/__/__

1. Was your child born in a high risk region? (Nacio su hijo/hija en una region o pais de alto riesgo?)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
2. Has your child ever traveled to a high risk country for more than 1 week? (Alguna vez ha viajado su hijo/hija a un oais de alto riesgo por mas de una semana?)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3. Has a family member or contact had tuberculosis disease? (Ha tenido un pariente o familiar con tuberculosis?)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
4. Has a family member or close contact had a positive Tuberculin skin test? (Alguien en su familia ha tenido una prueba de tuberculosis con resultado positive?)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

High Risk Regions include/Una region de alto riesgo incluye cualquier pais en:
Africa, Asia, Central America, South America, or Eastern Europe

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AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Patient Name:_____Medical Record #_____
Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   YOUR PRIOR PROVIDERS OFFICE: (Please list one provider or office per form)
   Doctor's Name:_____
   Doctor's Address:_____
   Doctor's Office Phone/Fax:_____

3. **The type and amount of information to be used or disclosed is as follows:**
   ***Must Be Checked Off (include dates where appropriate)**

- ☐ **Progress Notes**
- ☐ **Laboratory Reports** **from_____to_____**
- ☐ **Radiology Reports/Image Reports** **from_____to_____**
- ☐ **Consultation Reports** **from (Dr.'s name)_____**
- ☐ **Immunization Records**
- ☐ **Any and All records**
- ☐ **Other:_____**

4. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome(AIDS), or Human Immunodeficiency Virus(HIV). It may also include information about behavioral health or mental health services and treatment for alcohol or drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

   Heritage Victor Valley Medical Group (Attn: Medical Records)
   12408 Hesperia Road, Suite2
   Victorville, CA 92395
   Phone 760-553-7000 Fax 760-269-1277

   For the purpose of _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the rights to contest a claim under the policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____.

If I fail to specify an expiration date, event, or condition, this authorization will expire in six months from the date on which it was signed.

7. I understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and information may not be protected by federal rules.

_____

Signature of patient/Legal Representative Date Signature of person releasing records Date

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.