Registration Packet

The registration process at most physicians' offices is time consuming, redundant, frustrating, and usually not very fun. We have attempted to dramatically streamline the registration process but are still required to gather a large amount of information in order to deliver health services.

To facilitate your completion of this paperwork we offer these materials online for all new patients. Please find the following documents within this package.

- **Patient Partnership Agreement:** Describes the relationship we hope to develop with each patient in order to provide the very best health outcomes.

- **Patient Registration Information:** Streamlined, logically organized, and as simplified as we could get it.

- **Patient Health History:** This section is meant to be detailed and provide your complete health history information in order to save both you and the physician time during the initial health exam. Please take your time and fill out all pages completely.

- **Patient Privacy Preferences:** We take the privacy of your personal health information seriously and want to know how and with whom we can share it.

- **State of Insurance Eligibility:** Most patients still use health insurance to pay for health care. We want our patients to understand their responsibilities in the event that their insurance does not cover any health services.

- **Notice of Privacy Practices:** This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

We hope this provides a helpful orientation and makes your subsequent visits much faster and more enjoyable. We appreciate you being a member of OC Sports & Wellness and look forward to assisting you in the optimization of your health.

Patient Partnership Agreement

Achieving your **best possible health** requires a partnership between you and your physician. As "partners in health," we want to encourage you to work with us in the following ways:

Take a proactive role in your health. I understand that I am responsible for my health and that I am entering into this partnership to help achieve the best possible health for me. My physician will make recommendations regarding certain health screenings during my annual health exam appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.) in order to optimize my health and detect any potentially serious health conditions. I understand that if I don't complete these screenings I place myself at risk.

Keep follow up appointments and reschedule missed appointments. I understand that my physician will want to know how my health changes after my appointment and throughout the year. Regular visits with my physician provide opportunities for ongoing assessments of my health. During these appointments, my physician might order tests, refer me to specialists, prescribe medication, or manage a serious health condition. If I miss an appointment, I run the risk that my physician will not be able to assist in optimizing my health. Also, I will make every effort to reschedule missed appointments.

Call the office when I do not hear the results of any diagnostic tests. I understand that my physician's goal is to report all my diagnostic test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my results.

Inform my doctor if I choose not to follow the recommended treatment plan. I understand that after examining me, my physician may make certain recommendations based on his or her assessment. This might include prescribing medication, referring me to a specialist, ordering diagnostic tests, or even asking me to return to the office within a certain time period. I understand that not following my treatment plan can have serious negative effects on my health. I will inform my physician whenever I decide not to follow recommendations so that my physician may fully inform me of any risks associated with my decision to not follow treatment plan recommendations.

Thank you for you agreeing to partner together with us on your health. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please do not hesitate to ask.

_____ _____

Patient Signature Date

Registration Form

PATIENT INFORMATION

Last Name	First	Middle	Marital Status Single / Mar/ Div / Partner / Widow			
Street Address	City	State	Zip			
Birthdate	Sex M F	Social Security #				
Email Address (to sign up for the patient portal)	Occupation					
Home Phone ( )	Cell Phone ( )	Work Phone ( )				
If Minor, Legal Guardian:	Guardian Phone ( )					
Emergency Contact	Relationship	Phone				
How did you hear about our clinic?	Family	Friends	Physician	Search	Health Ins	Other
What features are most valuable to you?	Same Day Appointments	Online Scheduling	Email			
	Personal Health Record	Extended Hours	No Wait			

INSURANCE INFORMATION

Primary Insurance		Primary Ins. Phone	
Subscriber Name		Policy/ID Number	
Subscriber SSN		Group Number	
Relation to Patient		Co-pay Amount	
Secondary Insurance		Secondary Ins. ID Number	
Employer		Employer Telephone	
Employer Address			

AUTHORIZATION AND ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I consent to medical treatment by OC Sports and Wellness (OCSW) medical providers and its affiliates. I authorize the release of information required to process my claims and for my health benefits to be paid directly to OCSW. I understand that I am financially responsible for any balance remaining after the payment of health benefits.

_____ _____

Patient/Legal Guardian Signature **Date**

Health History

SYMPTOMS- Please place a check mark if you currently have or have had symptoms in the past year.							
✓	**General**	✓	**Gastrointestinal**	✓	**Ear, Nose, Throat**	✓	**MEN Only**
	Chills		Poor Appetite		Bleeding Gums		Breast Lump
	Depression		Bloating		Blurred Vision		Erectile Difficulty
	Dizziness		Bowel Changes		Difficulty Swallow		Testicle Lump
	Fainting		Constipation		Double Vision		Other
	Forgetfulness		Diarrhea		Earache		
	Headache		Excessive Thirst		Ear Discharge		**WOMEN Only**
	Loss of Sleep		Hemorrhoids		Hay Fever		Abnormal Pap
	Loss of Weight		Indigestion		Hoarseness		Irreg Periods
	Nervousness		Nausea		Loss of Hearing		Breast Lump
	Numbness		Rectal Bleeding		Nosebleeds		Painful Periods
			Stomach Pain		Persistent Cough		Hot Flashes
	Muscle/Joint		Vomiting		Ringing in Ears		Nipple Discharge
	Neck/Shoulder		Vomiting Blood		Sinus Problems		Painful Intercourse
	Arms/Back						Vaginal Discharge
	Legs/Hips		**Cardiovascular**		**Skin**		Other
	Feet/Hands		Ankle Swelling		Bruise Easily		Last Period
			Chest Pain		Hives/Itching		Last Pap
	Genito Urinary		High Blood Press		Rash		Last Mammo
	Frequent Urination		Irreg. Heartbeat		Open Sores		
	Painful Urination		Low Blood Press				
	Blood in Urine		Poor Circulation				
	Poor or Inconsistent		Varicose Veins				
	Bladder Control						

Personal History

MEDICATION- List all medications you are currently taking along with doses

SUPPLEMENTS – List any over the counter supplements you take on a regular basis

ALLERGIES- List all prior medications you are allergic to	
Medication	**Reaction**

HOSPITALIZATIONS, SERIOUS ILLNESS, OR INJURY		
Year	**Hospital**	**Reason and Outcome**

FEMALES: Pregnancy History		
Year	**M/F**	**Complications**

Family & Social History

FAMILY HISTORY –Fill in health information about your family							
Relation	**Age**	**Health Status**	**Age at Death**	**Cause**	**X**	**Disease**	**Family Member(s) with Condition**
Father						Arthritis, Gout	
Mother						Asthma, Allergies	
Brothers						Cancer	
						Chemical Depend.	
						Diabetes	
						Heart Disease/Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Other	

HEALTH HABITS			
On average, how many alcoholic beverages do you consume per week?			
How many caffeinated beverages do you consume per day?			
On average, how many days a week do you exercise for 30 minutes or more?			
Average stress level (low, medium, high)			
Do you smoke?	Yes No	Do you have a prior history of smoking?	Yes No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this for.

_____ _____

Patient or Authorized Signature Date

Privacy Preferences

As your health partner, we often have to communicate sensitive, personal health information. This information is protected by federal privacy laws and serves as:

- A basis for planning my care and treatment
- A means of communication between health professionals on my team
- A tool for routine health care operations such as assessing quality and outcomes
- A source of information for creating my bill for health services

We take the privacy of your personal health information seriously and seek to understand your preferences in communicating personal health information to you.

Please indicate your privacy preferences below:

1. List the individuals whom may share your personal health information with:

2. List the physical address that we can send your personal health information:

3. May we leave personal health information on a voicemail? ___yes ____no

   If “yes” what is the preferred phone number? _____

In addition, I acknowledge by my signature below that I have the right to be provided a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. Should any further questions, comments, or concerns arise please do not hesitate to contact our offices.

_____	_____	_____
Print Name	Signature	Date

Statement of Insurance Eligibility

Many individuals use health insurance to pay a portion of their health services. We require that each individual paying for their health services with health plan benefits sign a form declaring their eligibility as well as acknowledging that they are still responsible for payment of their health services should they be found ineligible for any reason.

I certify and declare that I am eligible for health plan benefit coverage as demonstrated by my presenting my health insurance card and that I have chosen OC Sports and Wellness to provide health services to me.

Furthermore, I certify and declare that if I am found ineligible for health plan benefit coverage, I will be financially responsible for all costs incurred during the delivery of health services and agree to pay these charges to OC Sports and Wellness according to the Patient Partnership Plan I have signed.

If I do not have health insurance, I agree to pay in full for services rendered on the day I receive them unless a payment plan has been previously agreed upon.

_____ _____

Patient/Guardian Signature Date

Notice of Privacy Practices Acknowledgement

OC Sports and Wellness, 26700 Towne Centre Dr. Ste 100, Foothill Ranch, Ca 92610

Privacy Officer: Christy Phone: (949) 460-9111

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

□ Parent or guardian of minor patient

□ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

OC Sports and Wellness Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Fees and Payments

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, personal check, Visa, MasterCard, American Express or Discover

Insurance co-payments are due at the time of service. If you are unable to pay your co-payment at your visit, your appointment may need to be rescheduled.

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Your insurance is a contract between you, your employer and the insurance company, we are not party to the contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not cover therefore we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at check in:

1. Verify personal contact information
2. Present current picture ID
3. Payment of any outstanding balance
4. Payment of today's visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for your visit.

Medicare

We gladly accept patients with Medicare and will bill our services at the allowed rate. Medicare regulations require that you sign an Advanced Beneficiary Notice (ABN) at every visit. This form helps to explain which service Medicare may not cover and may be your responsibility. Lab work will require a separate ABN signature.

Annual physicals and Well Woman Exams

Please verify that your insurance will cover these preventative services before making your appointment. Depending on your age and the plan, these services may not be covered. Also, some insurance companies are very strict in enforcing time limits between visits and may not cover your visit if you are even one day early.

Returned check charge – Non sufficient funds checks are subject to a $25 fee (in addition to fees from your bank)

Collections charge – Accounts that are not paid within 60 days from the due date may be sent to an external collection agency. In addition to your outstanding balance, a $10 collection fee will be added to cover our cost. In addition, you may be removed from our practice.

Lab charges- Depending on your insurance, you may get a separate bill from the lab facility that performs your lab work. These charges should be discussed directly with the lab facility.

Patient name (printed):_____

Patient Signature: _____ Date: _____