



MRN: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Cell phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Imaging Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Laboratory Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relation: \_\_\_\_\_

Email Address: \_\_\_\_\_

**LEGAL GUARDIAN/ GUARANTOR INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Cell phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_



MRN: \_\_\_\_\_

**PATIENT HEALTH INFORMATION**

**MEDICATIONS:**

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

---

---

---

---

---

---

---

---

---

---

**ALLERGIES:** \_\_\_\_\_

**MEDICAL HISTORY:**

*(circle all current and past medical problems)*

- |           |                          |                  |                    |
|-----------|--------------------------|------------------|--------------------|
| Anemia    | Irritable bowel syndrome | Heart disease    | Liver disease      |
| Anxiety   | Coronary Artery Disease  | Hepatitis        | Pulmonary Embolism |
| Arthritis | Deep Vein Thrombosis     | High Cholesterol | Reflux/GERD        |
| Asthma    | Autoimmune disease       | Hypertension     | Seizures/Epilepsy  |
| Diabetes  | Hyperthyroidism          | Kidney stones    | Depression         |
| Gout      | Hypothyroidism           | Tuberculosis     | Bleeding disorder  |
| Stroke    | Heart Attack             | Kidney disease   | Diverticulitis     |
| COPD      | Cardiac disease          | Rectal Bleeding  | Cancer             |



MRN: \_\_\_\_\_

***SURGICAL HISTORY:***

*(Please list all surgeries and the date of service)*

---

---

---

---

***FAMILY HISTORY :***

*(List any 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:***

Occupation: \_\_\_\_\_ Heavy lifting required?: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Previous Smoker?: \_\_\_\_\_ Current Smoker?: \_\_\_\_\_ How much in a day? \_\_\_\_\_ Years of use? \_\_\_\_\_

Do you drink Caffeine?: \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Do you drink Alcohol?: \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Previous Illicit Drug use? \_\_\_\_\_ Current Illicit Drug use?: \_\_\_\_\_

Chewing Tobacco? \_\_\_\_\_ Do you have an Advanced Directive? \_\_\_\_\_



MRN: \_\_\_\_\_

## AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

275 Grass Valley Hwy, Auburn, CA 95602

225 Colfax Ave, Grass Valley, CA 95945

**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 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: \_\_\_\_\_



MRN: \_\_\_\_\_

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."

"Effect of Refusal to Sign Authorization 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 receive a copy of this authorization upon request.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Legal Guardian/Guarantor:**

If not signed by the patient please indicate the relationship: \_\_\_\_\_



MRN: \_\_\_\_\_

## **PATIENT FINANCIAL PARTNERSHIP POLICY**

**(Version 1.0)**

To Our Patients:

We are pleased that you have chosen Sierra Doctors Medical Group, Inc. 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 *Sierra Doctors Medical Group, Inc.* 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 will be electronically debited from your account the day of service. Returned checks will be subject to collection fees.



MRN: \_\_\_\_\_

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, *Sierra Doctors Medical Group, Inc.* 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 3<sup>rd</sup> 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.

*Sierra Doctors Medical Group, Inc.* understands that there are many reasons why you may be seeking out care from our facility, whether it be for your primary care or an unexpected urgent care visit. 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 and Office Policy**

By signing below, you certify that you have received, read, and understand *Sierra Doctors Medical Group, Inc.* Patient Financial Partnership Policy. **(Version 1.0)**

*I understand that SDMG may, at its discretion, change the terms and conditions of their policies. I understand that I may request a copy of Sierra Doctors Medical Group Office Policy and 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 SDMG 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 SDMG.*

*I understand SDMG'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 SDMG. I understand that SDMG 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 SDMG.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





MRN: \_\_\_\_\_

**MEDICAL RECORDS RELEASE FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I hereby authorize the disclosure of my protected health information as defined by Federal and State law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care-provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

**The Health Information may be disclosed FROM:**

**Name of Facility or Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Phone#:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**The Health Information may be disclosed TO:**

**Sierra Doctors Medical Group, Inc.**

**Auburn Location:**

275 Grass Valley Hwy, Auburn, CA 95602

P: (530) 885-0344 F: (530) 885-8967

**Please indicate the type of records to be disclosed:**

\_\_\_\_\_  
\_\_\_\_\_

**This Health Information will be used for the purpose of:**

**Transfer Care**       **Personal**       **Other**

*I understand that my health care will not be affected if I do not sign this form.  
I understand that unless I specify an expiration date this authorization will expire one year from the date of my signature below. I also understand that I may revoke this authorization at any time by notifying the above noted Doctor/Facility in writing. I understand that my revocation of this authorization will not affect any actions taken by Sierra Doctors Medical Group in reliance on this authorization prior to the time it received my revocation.  
I understand that I have a right to receive a copy of this authorization.*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

-----

*Date faxed:* \_\_\_\_\_ *Initials:* \_\_\_\_\_