Newsom Healthcare PATIENT REGISTRATION FORM Please Print

Patient: Last name_____First_____Middle Initial _____

Mailing Address: _____City_____State_____Zip_____

Preferred phone: _____Alternate phone_____

Date of birth: _____ Gender: Male_____ Female_____ Social Sec. No_____

Email_____ Driver's License State and No_____

Marital Status: Single___ Married___ Other_____ Spouse/Partner name_____

Place of Employment_____Job Title_____

EMERGENCY CONTACT Name_____Phone_____Relationship_____

If patient <18 years old, Parent Name _____

How did you hear about us? _____Preferred Pharmacy:_____

Pharmacy Address: _____ and phone no_____

INSURANCE INFORMATION: If no insurance please check here ____ skip this section and sign at bottom.

Insurance Company Name _____Patient Relationship to subscriber: __self__spouse__child__other_____

Insurance subscriber's Name _____Subscriber Date of Birth_____

Insurance Member ID_____Group #_____CoPay amount_____

Do you have a secondary Insurance? ___yes ___no IF yes, Please complete the secondary Insurance information below:

Insurance Company Name _____Patient Relationship to subscriber: __self__spouse__child__other_____

Insurance subscriber's Name _____Subscriber Date of Birth_____

Insurance Member ID_____Group #_____CoPay amount_____

TO BE SIGNED BY ALL PATIENTS WITH INSURANCE: including Medicare and Medicaid. I authorize any holder of medical or other information about me to be released to the Social Security Administration, the Medical Commission, or any third party payor, or their intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance to the clinic.

Assignment Authorization Signature_____date_____

The following is the Authorization for Medical Care that **ALL Patients MUST sign**

1. I give permission to the providers of Newsom Healthcare to render care to me or those for whom I am responsible as the Provider advises is necessary and in the case of emergency.
2. I give permission for Newsom Healthcare to communicate with me by methods as indicated above.
3. I hereby authorize Newsom Healthcare to furnish such professional information as may be necessary from my records compiled by Newsom Healthcare including provider services, and hereby release Newsom Healthcare from all liability that may arise from the release of the information requested.
4. I/we agree to ACCEPT COMPLETE RESPONSIBILITY for all charges and agree to pay the same at the time services are rendered or according to specified payment (non-covered Medicare, Medicaid, Private Insurance charges). In the event of default, I agree to pay all costs of collection, including any reasonable attorney fees.
5. I agree that I have read and understand the above consent and will accept its terms.

Patient Signature or responsible party _____date_____

Newsom Healthcare Medical History Questionnaire Today's Date _____

Patient's Name _____ Gender: Male Female Date of Birth _____

1. Have YOU or family members been diagnosed with any of the following : Place an X as appropriate

	Self	Father	Mother	G/Parent	Brother/ Sister
Alcoholism	____	____	____	____	____
Anemia/Sickle Cell	____	____	____	____	____
Arthritis	____	____	____	____	____
Asthma	____	____	____	____	____
Cancer	____	____	____	____	____
Cholesterol Disorder	____	____	____	____	____
COPD/Lung Problems	____	____	____	____	____
Depression/Anxiety/psychological	____	____	____	____	____
Diabetes	____	____	____	____	____
Headaches	____	____	____	____	____
Heart Problems	____	____	____	____	____
High Blood Pressure	____	____	____	____	____
Kidney/Bladder	____	____	____	____	____
Seizures/Neurological	____	____	____	____	____
Thyroid disorder	____	____	____	____	____

2. Name any other medical problems that you have _____
3. **ARE YOU ALLERGIC TO ANY MEDICATIONS? YES or NO** If so list _____
4. Circle any of the surgeries or procedures that you have had.

   No surgeries Appendix removal Blood transfusion Gallbladder removal Hernia repair

   Heart surgery Hysterectomy Pacemaker Prostate Surgery Stomach surgery

   Spleen surgery Tonsils/Adenoids Tubal Ligation Thyroid surgery

   List any additional surgeries or procedures_____
5. Number of pregnancies _____ and number of live births _____
6. Please check the appropriate social history:
   1. Tobacco use ____no ____yes ____former smoker ___packs per day and ____years smoked ____years quit
   2. Alcohol use ____never ____rarely ____occasional ____moderate ____heavy
   3. Drug use ____no ____yes (if yes, please list drugs _____)
7. Please list your medications below. Provide the strength/dosages and how often the med is taken.
   1. _____ 7._____
   2. _____ 8. _____
   3. _____ 9. _____
   4. _____ 10._____
   5. _____ 11._____
   6. _____ 12._____

Newsom Healthcare

I hereby authorize this office to release my health information (PHI), including account status, scheduled appointments, and information regarding my treatment, to the persons I have listed below:

Name _____ DOB: ____/____/_____ Contact Info: _____

Name: _____ DOB: ____/____/_____ Contact Info: _____

1. **When notifying me of lab or test results, matters relating to prescriptions, appointments and account status, my preferred method of contact is:**

Cell: _____ Email: _____

Other: _____

May the practice leave a message at the above phone numbers? YES ____ NO ____

Mailing Address: _____

2. **Effective Period**: This authorization for release of information covers the period of healthcare from:

☐ All past, present, and future periods **OR** ☐ ____/____/_____ to ____/____/_____

3. **Extent of Authorization**

☐I authorize the release of my complete health record

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I, _____, understand ALL of the above and I have been notified of Newsom Healthcare's Notice of Privacy Practices and have been offered a copy of these practices.

_____ ____/____/_____

Signature of Patient or Representative **DOB**

____/____/_____

Date

NEWSOM HEALTHCARE Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is effective as of 12/16/2008 and remains in effect until we replace it.

Newsom Healthcare understands that your medical information is personal and we are committed to protecting your privacy. We are required by law to maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices with respect to your Protected Health Information (PHI). PHI is any health information, which is identifiable to you. We collect information about you and store it as the record of care and services you receive at our facility. If you have questions about any part of this notice or if you want more information about the privacy practices or your privacy rights at Newsom Healthcare please contact a staff member.

Newsom Healthcare may Use or Disclose Your Protected Health Information (PHI) for the following:

1. Treatment. Newsom Healthcare is a primary and preventive healthcare clinic that utilizes contracted providers and other business associates in order to provide quality care and treatment. We may disclose information about you to doctors, nurses, technicians or other people who are taking care of you.

2. Payment. We may use and disclose PHI for payment purposes. We may disclose you PHI to payors such as: Insurance companies (including HMOs, PPOs, Medicare, etc.) employers, and others who arrange or pay the cost of some or all of your health care. Your insurance company may release your PHI to the primary policy holder.

3. Health Care Operations. Your PHI will be provided to Newsom Healthcare employees or business associates who participate in meeting your health care needs. This includes but is not limited to: scheduling appointments, appointment reminders, greeting you on arrival, assisting y our provider during the office visit, arranging referrals, and maintaining your records. We may use your PHI to evaluate the quality and competence of our staff.

4. Information Provided to You. Upon your signed authorization, information will be released to you.

5. Notification and Communication with Family. We may disclose your PHI to a family member, your personal/legal representative (one who has a valid Power of Attorney for Health Care, a conservator, or a guardian) or another person responsible for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by Law. As required by law, we may use and disclose your PHI.

7. Public Health. As required by law we may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health Oversight Activities. We may disclose your PHI to health agencies during the course of audits or investigations.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509f HHH Building
Washington, DC 20201

You may also address your complaint to one of the regional Offices for Civil Rights. A list of these offices can be found online at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html

In the event these policies change. Newsom Healthcare will revise this notice and make it available to you upon request.