REGISTRATION FORM

Today's Date:	SSN:

PATIENT INFORMATION

First Name:	Middle	Last	Sex: □ M □ F	Birth Date: / Age:
Current Address:	Zip	City	State	

Home Phone:	Cell Phone:	Email:

Preferred Method of Communication:	Marital Status:
□ Home Phone □ Cell Phone □ Email	□ Child(<18yo) □ Single □ Married □Divorced □Separated □ Widow

Where did you hear about us: □ Google □ Bing □ Other Search Engine □ Yelp □ Direct Mail □ Insurance Company

□ San Clemente Times □ Referring Physician/Professional : ________________________________ □ Family □ Friend

□ Close to work/home □ School:______________________________ □ Other: ________________________

INSURANCE INFORMATION (write SAME if Patient is the Primary Holder)

Primary Policy Holder: First Name	Middle:	Last Name:
Street Address: Zip	City	State

Home Phone:	Cell Phone:	Social Security Number:	Birth Date:

Relationship to the Patient:	Has the Policy Holder been a Patient of Hybrid MD? □ Yes □ No	Sex: □ M □ F

Check the following box for your primary insurance:	□ Blue Cross □ Blue Shield □ Humana □ Health Net □ United HealthCare □ Tricare □ Medicare □ Cigna □ Aetna □ HMO Medical Group: _________________ □ Other:____________________

IN CASE OF EMERGENCY / NEXT OF KIN

First Name	MIddle Name:	Last Name:
Street Address: Zip	City	State

Home Phone:	Cell Phone:	Email:	Relationship to the Patient:

PATIENT INFORMATION

NAME: ____ **DOB:** ___ /____ /____ **DATE:** ___ /___ /___

***Right Handed / Left Handed** ***Last Tetanus:** ___ / ___ / ___ ***Updated:** ___ / ___ /___ **Patient's Initials:** ________

Welcome to Hybrid MD in San Clemente. Our commitment to you, our patient, is to give you the highest quality care and the best customer service. In order to do that, we need your help. By answering the questions below, you will not only help yourself and your health care team, but also increase the efficiency of our medical services. In all cases, please be as complete as possible. If there are questions that are not clear to you, please bring them up to our staff. We are happy to assist you and answer your questions.

PAST MEDICAL PROBLEMS: CHECK IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

___ Migraine Headaches ___ Lung problems ___ Heart problems ___ Blood transfusion

___ Seizures ___ High blood pressure ___ Leg swelling ___ Blood clot

___ Diabetes ___ Elevated Cholesterol ___ Stomach ulcers ___ Blood from rectum

___Tuberculosis (TB) ___ Elevated triglycerides ___Kidney/bladder issue ___ Other: ____________

SURGERY: Please list operations and year done: ____

Please check if there is a family history of diseases listed below and write your relationship of family member:

___ Stroke: ____________________ ___ Heart Disease: _______________ ____ Kidney Problems: _____________

___ Asthma: ___________________ ___ Stomach problems: ___________ ____ Cancer: _____________________

___High Blood Pressure: _________ ___ Diabetes: ___________________ ____Emphysema: _________________

___Psychiatric problems: ____________________ _____Other: ________________________

Pregnancy (woman): Have you ever been pregnant? Yes / No How many times: ________________________________

How many children? _______________ Date of LAST menstrual period: ____________________

Please list your medications: (*if there is more than the space provided, please inform the nurse/doctor. If you have a list, please provide it to the frontdesk*)

Name of Medication	Dose	Frequency (how often)	Reason for taking it

Please list your allergies to medications: (*if there is more than the space provided, please inform the nurse/doctor. If you have a list, please provide it to the frontdesk*)

Name of Medication	Reaction

Do you smoke? Yes / No How many a day? _____________ For how many years? __________ Quit: ________

Do you drink alcohol? Yes / No How much a day? _____________ For how many years? __________ Quit: ________

Use any non-prescription drugs (eg: vitamins or supplements)**? Yes / No** ____

REVIEW OF SYMPTOMS

FOR THE FOLLOWING CONDITIONS, PLEASE CHECK IF YOU CURRENTLY HAVE:

General Health:

[ ] Fever [ ] Chills [ ] Recent weight loss [ ] Other

Neurological:

[ ] Dizziness [ ] Headaches [ ] Numbness [ ] Weakness

Eyes:

[ ] Change in vision [ ] Pain [ ] Redness [ ] Discharge

Ears, Nose & Throat:

[ ] Earache [ ] Ear discharge [ ] Sinus congestion [ ] Sore throat

Neck Region:

[ ] Mass [ ] Swollen Glands [ ] Stiffness [ ] Other

Thyroid:

[ ] Tenderness [ ] Neck Mass [ ] Other: ____________________________________

Cardiovascular (Heart):

[ ] Chest pain [ ] Palpitations [ ] Abnormally rapid heartbeat (flutter)

Respiratory (Lungs):

[ ] Restrictions [ ] Wheezes [ ] Cough [ ] Shortness of breath

Gastrointestinal:

[ ] Pain [ ] Nausea [ ] Vomiting [ ] Diarrhea [ ] Constipation

Genitourinary:

[ ] Blood with urination [ ] Burning with urination [ ] Urgency [ ] Frequency

Skin:

[ ] Rash [ ] Ulcers [ ] Lesions [ ] Abrasions

Musculoskeletal:

[ ] Muscle pain [ ] Joint pain [ ] Edema [ ] Other _____________

____________________________	____________________________	____/____/____	___________________________________
Patient's Last Name	**Patient's First Name**	**Date**	**Patient's Signature (Representative if minor)**

Primary Doctor (PCP): ______________________________________

PCP Phone #: ______________________________________

Preferred Pharmacy Name & Address: _________________________

(*please let us know* ____

if there's a change) ____

Pharmacy Phone #: ____

FINANCIAL & MEDICAL CONSENT FORM

1. **SAFE ENVIRONMENT FOR PATIENT CARE:** Weapons or other dangerous objects, illegal drugs and drugs not prescribed by the patient's physician are not permitted in the guest treatment area. The medical center obligation to provide a safe environment for patient care must override the patient's right to privacy. The medical center reserves the right to search the patient treatment area to confiscate such objects upon reasonable probable cause.
2. **FINANCIAL AGREEMENT: (I)** The undersigned agrees whether he/she signs as agent or patient that inconsideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the medical clinic in accordance with the regular rates and terms of the medical clinic and/or as set forth by the terms of managed care contracts entered into by medical center. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney fees and collection expense. All delinquent accounts shall bear interest at the legal rate. Hybrid MD has verified your eligibility online/over the phone. In order for us to see you today, we will need to collect $_________. Since we are not the actual processor of claim/payment, once your insurance carrier processes your claim, we will know your ultimate guest responsibility. You will receive an explanation of benefits notifying you of the final amount you will be responsible for. If we have over collected, we will send you a refund. If we have under collected we will balance bill you._______________ (**INITIALS**). **(II)** How do you want your visit to be billed today (please circle one)? **INSURANCE / CASH** ___________ (**INITIALS**). **(III)** I have been offered the self-pay/cash rate option.______________ (**INITIALS**). Please note that if you choose an insurance option, you cannot opt for the cash option after you leave the physician office._________________ (**INITIALS**). Please initial here if you understand the financial responsibility listed above _______________ (**INITIALS**). (**All fields must be filled out before seeing the physician**)
3. **RELEASE OF INFORMATION:** To the extent necessary to determine liability for payment and to obtain reimbursement, the medical clinic or attending physicians may disclose portions of the guest's records, including his/her medical records, to any person or corporations which is or may be liable, for all or any portions of the medical center's charge, including but not limited to, insurance companies & healthcare services plan. (Special permission is needed to release this information where the guest is being treated for alcohol or drug abuse.)
4. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or guest, direct payment to the medical clinic or physicians, medical groups and practitioners of any insurance benefits otherwise payable to the undersigned for his/her services at the rate not to exceed medical clinic regular charges. It is agreed payment to the clinic, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.
5. **MEDICARE INSURANCE BENEFITS AND EXCLUSIONS:** I certify that the information given by me in applying for payment under the title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I request that payment of authorized benefits be made on my behalf. Some services may not be covered by Medicare such as the following: 1) Worker's Compensation 2) Dental 3) Cosmetic Surgery 4) Custodial Care 5) Personal comfort items, and any service determined to be unnecessary or unreasonable by Medicare. The undersigned understands that the Department of Health and Human Services Healthcare & Financing Administration requires that the guest signature be released Medicare/Medical eligibility information. The undersigned authorizes the Social Security Administration to release the following information to medical health center.
6. **GUEST ENROLLED IN MANAGED CARE HEALTH PLAN:** I understand that I'm responsible for guarantee of my eligibility and obtaining approval for services from my PPO plan. Or I must plan for payment of service rendered at this time. I agree to be financially responsible for any and all charges for the visit if not covered by my health plan.
7. **GUEST ENROLLED IN CAL-OPTIMA/MEDI-CAL/MEDICAID:** Hybrid MD does not accept Medicaid, Medi-Cal or Cal-Optima, unless it is through Monarch Health System. We recommend that you go to a medical office that accepts your insurance. **However** if you choose to be seen here at Hybrid MD as **a "Cash Patient" (Non-Insurance Patient)**. You will **NOT** be able to submit your receipt of cash medical services rendered for refund to Medi-Cal, Medicaid or Cal-Optima, they **WILL NOT** give you a refund and we will not give you a refund for Medical Cash Services Rendered at Hybrid MD.**______________(INITIALS)**
8. **HEALTHCARE SERVICES PLAN:** This clinic maintain a list of healthcare services plan with which it has contracted. A list of such plans is available upon request from the financial office the medical clinic has no contract, express or implied, which any plan that doesn't appear on the list. The undersigned agrees that he/she is individually obligated to pay the full cost of all services rendered to him/her by the clinic if he/she belongs to a plan which doesn't appear on the above mentioned list.
9. **MEDICAL AND SURGICAL CONSENT:** The guest is in the care and supervision of the attending physician and it is the responsibility of the medical clinic to carry out the instructions of such physician. The undersigned hereby consents to X-ray examination, laboratory procedures, anesthesia, emergency treatment, medical or surgical treatment or medical clinic services rendered to the guest under general and special instructions of the physician.
10. **CONSENT TO PHOTOGRAPH:** The taking of pictures of medical or surgical procedures and the use of the same for scientific, education, or research purposes is approved.

The undersigned certifies that he/she has read the foregoing, receiving a copy thereof, and is the guest, or is duty authorized by the guest as guest's general agent to execute the above and accept its terms.

____	____ /____ /____	______________________________
Guest's Full Name & Date of Birth *(please print)*	**Date of Service**	**Guest's Signature**
(Representative if Patient is a Minor)		**(Representative's Signature if Patient is a minor)**

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to Inspect and copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (*full Notice is available upon request*)

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date on the first page.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Hybrid MD. If you have questions and would like additional information, you may contact us at:

Hybrid MD
1031 Avenida Pico Suite 103
San Clemente, CA 92673
Tel: (949) 429 1919 Fax: (949) 429 7267
Email: hybridmd@hybridmdoc.com

Effective date: September 15, 2014

I have read and understand the practice's policies with regards to privacy and security of personal health information.

_______________________________________ _______________________

Patient's or Representative's Signature **Date**

_______________________________________ _______________________

Patient's or Representative's Name (Please Print) **Patient's Date of Birth**