Family Care of Santa Maria

915 E. Stowell Rd Santa Maria CA 93454

P: (805)934.5140 F:(805)934.3500

Today's Date:	PCP:

PATIENT INFORMATION

Last:	First:	Middle:

Is this your legal name? Y N	If not, what is your legal name?	Maiden Name:

Birth Date:	Age:	Sex:	S.S.N

Address:	City:	State:	Zip:

Home Phone:	Cell:	Work Phone:

Occupation:	Employer:

Work Address:	City	Zip Code:

Chose clinic because / Referred by?	Other family seen here:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone:

Are they a patient here?	Y N	Is this patient covered by insurance?	Y N

Occupation:	Employer:	Address:	Phone:

Primary Insurance:	Group No.	Policy No.	Co-pay:

Subscriber/Policy Holder:	Subscribers D.O.B:	Subscriber's S.S.N

Relationship to subscriber:

Secondary Insurance:	Group No.	Policy No.	Subscriber:

Relationship to Subscriber:

IN CASE OF EMERGENCY

Name:	Relationship:	Home number:	Cell number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize, Okerblom, Voegele and Hole to relase any information required to process my claims.

Signature Date

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Name: ______________________ **D.O.B** ______________

HAVE YOU EVER HAD PROBLEMS WITH:

___ Headaches	___ Menstruation
___ Eyes, Ears or Throat	___ Sexual Function
___ Hay Fever	___ Depression
___ Heart	___ Arthritis
___ Breathing	___ Diabetes or Thyroid
___ Digestion	___ Cancer
___ Bowels	___ Weight Change
___ Neurological	___ Dizziness
___ Urination/Kidneys	___ Other

Please Explain: ______________________________________

____

____

Do you Smoke? _____ **Drink Excessively ?**______ **Exercise Regularly?** ______

Circle Diseases in blood relatives:

* Diabetes *Stroke *Heart Disease *Cancer *Thyroid

Allergies to medications:

____

List current medications (include strength and dose) :

____

List prior surgeries: ______________________________

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NOTICE OF PRIVACY PRACTICE

The medical practice of Doctor's Robert W. Okerblom M.D., Donald J. Hole M.D., Rachel Zonca D.O., Sean Christiansen D.O., Peter D. Scott M.D and Associates have implemented policies to protect the privacy of your medical records. The following is a description of how we manage your individual medical information.

A written or electronic record of your health care is constructed at each encounter. This record may include your symptoms, examination, test results, treatment plans, outside records, and other medical information. Transcription services are often utilized. Our emplyees access this record only for legitimate medical or buisness reasons. All employees are trained in patient confidentiality procedures. Safegaurds are taken to prevent the unintended disclosure of your health and information during creation, utilization, storage and destruction. Anything that identifies a patient with their individual medical care is protected.

By law, your medical information may be shared (without your authorizatio) for:

1. Treatment- To facilitate your care we may share information with consulting physicians, health care entities, Public Health and legal entities , and on call physicians. For example, we will send a consulting physician relative chart notes.
2. Payment- To obtain payment from third parties, we will provide requested information to insurers. For example, your insurance company may request chart notes before payment.
3. Healthcare operations- We may supply medical information for the purpose of quality control, business activites, and other healthcare operations. For example, we may need to call your home to remind you of an appointment.

Any other disclosures of your medical record will require your written or expressed authorization. This even includes disclosures to non-dependent family members. All disclosures of your record requiring authorization will be documented.

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You have certain rights regarding your individual records, including the right to:

1. To inspect and copy your records and it's disclosures. Certain conditions like legal actions may restrict this right. Written 30 days notice is required prior to inspection, and a supervision fee may be required.

2. To request restrictions and amendments regarding your record your request must be in writting, specific, and time sensitive. We will accept or deny your request in writing. Special handling creates a burden for us and we may charge a fee.

3. To file written complaints concerning your records to our office manager.

4. To revoke in writting any prior disclosure authorizations at any time.

5. To request in writting that we communicate with you in alternative methods.

Some of the specific actions we have taken to protect your privacy include:

1. All employees with access to your medical records are trained to protect your privacy. Privacy training includes both, in the office and in the community.

2. Contracted and business associates with access to your medical records have been instructed regarding confidentiality handling of your record and have signed agreements to protect your privacy.

3. Your medical records and demographics information is never knowingly sold or otherwise released for non-medical or commercial purposes.

If there are any parts of this privacy policy you do not understand, please consult with our office manager. We are happy to address any of your questions or concerns.

A written copy of this notice is available upon request

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

____________________________________ ______________

Signature of Patient/ Patient Respresenative **Date**

____________________________________ ______________

Patient Name **D.O.B**

____

Relationship to Patient

ASSIGNMENT OF BENEFITS

I authorize this office to release to the beneficiary's insurance companies any information necessary to expedite insurance payment. I authorize payment directly to the provider service.

I understand that I am responsible for all charges, regardless of insurance coverage.

____

Patient, Parent or Legal Guardian Signature

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Missed Appointment Policy for New Patient

As a new patient, if you are not able to keep your appointment please call and cancel or reschedule 24 hours in advance. By cancelling or rescheduling in advance this allows the doctor's time to be spent efficiently and for our other patients to receive timely care. If you do not cancel / reschedule and miss your appointment there will be a $50.00 charge.

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SERVICES NOT COVERED BY YOUR INSURANCE

Many patients request services from our office that are not covered by your health insurance provider. While we are willing to assist with these requests, they often require significant staff time and resources. Consequently, we must charge a fee to complete these services. Some examples of services not covered by your insurance are:

1. Competion of forms, DMV applications - $25
2. Completion of orginal disability forms - $25 Subsequent disability forms - $15
3. Copying medical records for patients personal use - $25 & up
4. Completion of medical mediation prior authorizations - $25 (Approved or Denied)

Please inquire in advance about your specific forms, letter ot services required.

PRINT NAME: ______________________________

SIGNATURE : ______________________________