NATOMAS
FAMILY PRACTICE INC.
convenience, compassion, community

Steve D. Hwang, D.O. Patrick C.Lau, M.D.

2410 Del Paso Rd. Sacramento, Ca 95834
Office: (916) 928-0856 Fax: (916) 928-1584

PATIENT DEMOGRAPHICS

DATE: _____ ☐MALE ☐FEMALE

PATIENT FULL NAME: _____

Date of Birth: _____ Social Security #: ___-___-____

EMAIL: _____

Circle One: Single Married Separated Divorce Widowed

PATIENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Patient Phone ( ) ___-____ Message Phone ( ) ___-____

***** IF PATIENT IS UNDER 18 YEARS OF AGE*****

Guarantor/Responsible Party Name: _____

Guarantor/Responsible Party Name SSN: _____

Relationship to Patient: _____ Date of Birth: _____

_____

Street City State Zip

Name of Primary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ Date of Birth: _____ SSN: ___-___-____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER: _____

Ins. ID/ Policy #: _____ Group #: _____ Effective Date: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone ( ) ___-____

Emergency Contact Address: _____

Natomas Family Practice
Patient History Form

(This medical document is strictly confidential and will not be released without your written authorization)

Last Name:_____ **First Name:**_____ **Middle:**_____

Date of Birth:_____ **Birth Place(City, State, Country):**_____

MEDICAL HISTORY

AIDS/HIV	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Polio	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Hemorrhoids	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Depression	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Other:_____		
Heartburn	☐ Yes	☐ No	Low Back Pain	☐ Yes	☐ No	Other:_____		

Date of Last: Tetanus Shot:_____ Sigmoidoscopy/Colonoscopy:_____
Mammogram:_____ Pap Smear:_____

Previous Surgeries:	**Date(s):**	**Hospital,City,State:**

Medications (please include prescription, over the counter, vitamins, herbal remedies, etc):

Name	Dose	Frequency

DRUG ALLERGIES:_____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily ☐ Binge
Tobacco Use: ☐ Never ☐ Previously, but quit in:_____ ☐ Current Use (packs/day):_____
Drug Use: ☐ Never ☐ Previously, but quit in:_____
☐ Current Use (type/frequency):_____
Education: ☐ High School_____Yrs ☐ College____Yrs ☐ Post Graduate____Yrs
Current Occupation:_____ Prior Occupation:_____
Have you ever experienced physical, emotional or sexual abuse in your home or relationship?_____
Please name a unique or interesting fact about yourself:_____

FAMILY HISTORY

	Name,Age(s)	Disease	If deceased, age and cause
Father:			
Mother:			
Siblings:			
Children:			

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

NAME_____, DATE OF BIRTH_____

RELEASE OF INFORMATION

{} NAME RELATIONSHIP _____

{} NAME RELATIONSHIP _____

{} NAME RELATIONSHIP _____

{} INFORMATION IS NOT TO BE RELEASED TO ANYONE

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT FOR ONE YEAR OR UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL {} MY HOME {} MY WORK {} MY CELL PHONE_____

IF UNABLE TO REACH ME:

{} YOU MAY LEAVE A DETAILED MESSAGE

{} PLEASE LEAVE MESSAGE ASKING ME TO RETURN YOUR CALL

OTHER_____

BEST TIME TO REACH ME IS (DAY) _____BETWEEN (TIME)_____

SIGNED:_____ DATE:_____

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Sacramento, CA 95834
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Natomas Family Practice's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

DOB: _____ _____
Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

- ☐ Showing the patient the Notice of Privacy Practices posted in our office.
- ☐ Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- ☐ Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- ☐ Asking the patient to sign this Acknowledgement form.
- ☐ Other (explain in detail)_____

_____

_____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):

- ☐ The patient refused to sign this form.
- ☐ The patient would not sign the form because the patient said he/she did not understand the Notice.
- ☐ Other (explain in detail)_____

_____

_____

Date: _____ Name: _____

Notes: This written Acknowledgement must be completed no later than the first date health care services or treatment are provided to the patient after December 12, 2016. This Acknowledgement must be retained in the patient's permanent records

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Office Visit below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Office Visit below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Office Visit Date:	Non covered benefits (Example)	$165.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Office Visit listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Office Visit listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Office Visit listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** Office Visit listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Patrick Lau, M.D. Steve Hwang, D.O.

Sharndip Taggar, NP

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FINANCIAL AGREEMENT

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THE CLAIM AND REQUEST THAT PAYMENT OF ANY BENEFITS BE MADE TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED BENEFITS AND ALL DEDUCTIBLES NOT COVERED BY THIS AUTHORIZATION. SHOULD THE ACCOUNT BE REFERRED TO AN ATTORNEY FOR COLLECTION, THE UNDERSIGNED SHALL PAY ACTUAL ATTORNEY FEES AND COLLECTIONS EXPENSES. **I UNDERSTAND THAT NATOMAS FAMILY PRACTICE DOES NOT HAVE A MEDI-CAL (GOVENEMENT SPONSORED INSURANCE) CONTRACT, AND THAT THEY WILL NOT BE BILLED. THEREFORE ANY EXPENSE INCURRED BY THIS PLAN WILL BE MY RESPONSIBILITY.** I CERTIFY THAT EVERYTHING ABOVE IS FILLED OUT TO THE BEST OF MY KNOWLEDGE.

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES TO YOUR INSURANCE, HOME OR MAILING ADDRESS AND PHONE NUMBER(S). PLEASE RETURN THIS SIGNED FORM TO THE RECEPTIONIST. THANK YOU FOR YOUR COOERATION.

SIGNATURE: _____ DATE: _____
(INSURED OR AUTHORIZED PERSON)

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Patient Name: _____

Date Of Birth: _____

PATIENT DEMOGRAPHICS QUESTIONNAIRE

We are asking for your race and ethnicity because some people have higher risk of developing certain diseases, such as high blood pressure, diabetes, and heart disease. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly. We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care. Thank You!

Please provide the information below. We greatly appreciate your participation!

1. **Race. Please mark what best describes you.**
(If more then one, please rank your selection by marking your primary race with a number 1, your secondary race with a number 2 and so on.)

☐ White/Caucasian	☐ Filipino	☐ Native Hawaiian
☐ Black/African American	☐ Japanese	☐ Guamanian or Chamorro
☐ American Indian or Alaska Native	☐ Korean	☐ Samoan
☐ Asian Indian	☐ Vietnamese	☐ Other Pacific Islander
☐ Chinese	☐ Other Asian	☐ Other_____

☐ I Prefer Not To Answer

2. **Are you of Hispanic Origin?** *(Please mark the ONE statement that best describes you.)*

☐ No, not Hispanic/Latino

If Yes:
- ☐ Cuban
- ☐ Puerto Rican
- ☐ Mexican, Mexican American, Chicano
- ☐ Other Spanish/Hispanic/Latino
  For Example: Argentinean, Colombian, Dominican, Nicaraguan, Salvadorian, Spaniard, etc.

☐ I Prefer Not To Answer

3. **What is your primary ancestry or ethnic origin?** *(Write up to FOUR ancestries)*
For example: Italian, Jamaican, African American, Cambodian, Cape Verdean, Norwegian, Dominican, French Canadian, Haitian, Korean, Lebanese, Polish, Mexican, Taiwanese, Ukranian, etc.

☐ I Prefer Not To Answer

Turn Over ➔ ➔ ➔

4. **Please indicate your preferred spoken language.**
(We are required by law (CA Health and Safety Code AB800, Section 123147) to request this information.)

☐ I Prefer Not To Answer

5. **Interpreter Services:** Would language interpreter services be helpful to you during your medical visit?

☐ Yes ☐ No ☐ I Prefer Not To Answer

The Importance Of Collecting Patient Data

1. **Why are we collecting this information?**
   - To improve clinical quality of care and provide the best care for all patients.
   - To better understand and address health differences among many communities.
   - To-date, we have used this information to help identify new health risks or predispositions among certain patient populations.

2. **Where do these questions come from?**
   - The questions we are asking come directly from the U.S. Census 2000*
   - This allows us to compare our information to national healthcare studies.

3. **What happens to the information from the survey?**
   - Your response will become part of your electronic medical record and your doctor will have access to this information.
   - This will help your doctor better evaluate your individual health risks.

4. **Is this Legal?**
   - The state of California requires that we collect patient's race, ethnicity and language for their health records**.
   - The office of Statewide Healthcare Planning and Development (OSHPD) requires all healthcare agencies to collect patient race/ethnicity/language as of 1/1/09***.

5. **What else will my response be used for?**
   - To measure and anticipate interpreter service needs.
   - To better develop patient communication materials.
   - To develop and implement cultural competence staff training.

http://www.census.gov/dmd/www/pdf.d02p.pdf
**Senate Bill 680: Patient Health and Safety Code, 2001; Assembly Bill 800, 2006
***www.oshpd.state.ca.us/HID/MirCal/Text.../POAPLSNOTICE.pdf

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No-Show/Late Cancellation Policy

I, _____, have been made aware
(patient name, if minor then parents name)

that as of July 1st 2014, there will be a No-Show/Late Cancellation Policy in effect. I understand that I must give the office notice of appointment cancellation at least 24 hours prior to my scheduled appointment time. If I fail to give 24 hours notice, I understand that I will be charged a fee of $25.

_____ _____

Patient/Parent Signature Date