MEDICAL REGISTRATION FORM

Patient Name: _____
(Last Name) *(First Name)* *(Middle Initial)*

Street Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Birth Date: _____

Cell Phone: _____ Sex: Male ☐ Female ☐

Work Phone: _____ SSN #: _____

Email: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____

Employer: _____

Work Address: _____

Spouse/ Legal Guardian Address: _____

Emergency Contact Phone: _____ SSN #: _____

Do you have a primary Doctor? Yes ☐/ No ☐ If yes, answer below:

Name of Doctor: _____ Phone: _____

Address: _____

If you do not have a primary doctor, would you want us to be your primary doctor?

Yes ☐/ No ☐

If you have chosen us as your primary doctor, it is your responsibility to come in yearly for your annual physical.

Primary insurance: _____ ID#: _____ Group # _____

Address: _____ Phone: _____

Insured Name: _____ Birth Date: _____

Relationship to Insured: _____ Insured SSN# _____

Do you have a secondary insurance? Yes ☐/ No ☐

If yes, request a secondary insurance form.

Consent for Treatment/ Authorization/ Assignment/ Responsibility Statement:

I consent to have Allmed Medical Center Physician(s) on duty and their Assistants to treat me in the facility.
I consent to have Physical Examination, Diagnostic Procedures, Surgical and Medical Treatment, Local Anesthesia given to me if necessary, the Prescription of Medication.
I understand that I am financially responsible for all charges for services rendered to me, including the balance remaining after payment of Medical Benefits for myself to Allmed Medical Center. I authorize payment of medical benefits for myself to Allmed Medical Center and authorize the release of any medical information necessary to process this claim. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balances on my account.
I have read this form or have had it read to me. I agree and understand what it says. I further acknowledge to have been shown the Notice of Privacy Policy. I have read and understood it. I have had all my questions answered on it. I hereby declare to agree to the contents of the Notice of Privacy Policy shown to me.

Patient/Legal Guardian Signature: _____ Date: _____

Allmed Howe
701 Howe Ave, Suite C
Sacramento, CA 95825
Phone: (916) 972-1100
Fax: (916) 800-7540

Allmed Elkhorn
5255 Elkhorn Blvd
Sacramento, CA 95842
Phone: (916) 334-1100
Fax: (916) 800-7540

Allmed Sunrise
2485 Sunrise Blvd Suite A
Rancho Cordova, CA 95670
Phone: (916) 281-2251
Fax: (916) 800-7540

Allmed Rio Linda
2469 Rio Linda Blvd
Sacramento, CA 95815
Phone: (916) 468-1100
Fax: (916) 800-7540

Allmed Fair Oaks
6600 Mercy Court, Suite 260
Fair Oaks, CA 95628
Phone: (916) 545-6001
Fax: (916) 800-7540

Allmed Roseville
729 Sunrise Ave, Suite 607
Roseville, CA 95661
Phone: (916) 755-0050
Fax: (916) 800-7540

ALLMED MEDICAL CORP

REPLY TO: (916) 303-7408

NOTICE OF DOCTOR'S LIEN

Patient: _ **Date of Accident:** _____

DOB: _____

I do hereby authorize **ALLMED MEDICAL CENTER** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injury for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor interest, the doctor will not await payment and may declare the entire balance due and payable.

Date:_____ **Patient Signature:** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

Date: _____ **Attorney Signature:** _____

PERSONAL INJURY INSURANCE & INSURANCE VERIFICATION

Was this accident: ☐ Auto ☐ Slip & Fall ☐ Motorcycle ☐ Homeowner 's

Date of Injury: _____

First Party (Patient)

Car Insurance: _____ Policy#: _____

Claim #: _____

Address: _____

Phone: _____

Relationship to Insured ☐ Self ☐ Spouse ☐ Child Other: _____

Adjustor: _____ Phone: _____

Have you reported the accident to your insurance company? Yes ☐/ No ☐

Third Party (Other Party)

Car Insurance: _____ Policy#: _____

Adjustor: _____ Phone: _____

Attorney Information

Name of Firm: _____ Phone: _____

Attorney's Name: _____ Fax: _____

I hereby authorize_____to make payment directly to Allmed Medical Corporation, 701 Howe Avenue, Ste. C-5, Sacramento, CA 95825. This is a direct assignment of my rights and benefits under this policy. A photocopy shall be considered as valid as the original.

Date:_____Signature: _____

******PLEASE PROVIDE COPIES OF ALL INSURANCE POLICIES/CARDS******

Adrian Birladeanu, M.D.
Board Certified in Pain Management
Board Certified in Physical Medicine & Rehabilitation

PAIN MANAGEMENT AGREEMENT

This is an agreement between_____and Dr. Adrian Birladeanu.
(Patient Name)

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily us of narcotics increases certain risks, which includes but are not limited to:

- Addiction
- Allergic reactions, overdose, and/or fatal complications
- Breathing problems
- Drowsiness, dizziness and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Development of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (see #2).
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement oflost or stolen medication. Refills will only be provided during regular office hours.
3. I will obtain ALL of my prescriptions through Dr. Birladeanu and will fill ALL of my prescriptions at (pharmacy name)_____ In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify my primary care physician as soon as possible.
4. I will submit to random urine or blood tests if requested by my physician to access my compliance. I agree to see Dr. Birladeanu for ongoing case management and will keep regularly scheduled appointments as long as I am taking this narcotic medication.
5. If I do not follow these guidelines, I understand that by treatment may be terminated.
6. I have discussed the risks, benefits, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Date: _____Patient Signature: _____

*** Dr. Birladeanu reserves the right to discharge a patient for any reason at any time.**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Patient Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Claim or Group #: _____

SS# or ID# _____

I hereby instruct the _____

Insurance Company to pay by check made out to and mailed directly to:

ALLMED MEDICAL CENTER
701 Howe Avenue, Suite CS
Sacramento, CA 95825

for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance

Dated at _____ County, this _____ day of _____

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU AY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on_____and remains in effect .until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We can create a record of care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the way we may use and share medial information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice

We Have the Right to:

1. Change our policy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any

specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice. **FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who have taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. **FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill bay include you medical information.

Patient Signature: _____Date: _____

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Heath Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the report of certain types of wound), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative an Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1 Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_____for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2 Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3 Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in the case of an emergency).

4 Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.

5 Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6 If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

FOR HEALTH CARE OPERATIONS: we may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be place in our facility directories, your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we sill share only the health information that is directly necessary for your health care, according to your professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your healthcare. In any fund raising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for the correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such a court order, warrant, or grand jury subpoena, we may share you medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to be enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: _____

Address: _____

Patient: _____ Date of Birth: _____

SSN#: _____ ID#: _____

I, _____ request the following information:

☐ X-rays ☐ History ☐ Records ☐ Diagnosis ☐ Treatment ☐ Reports ☐ Billings

Concerning my: ☐ Accident ☐ Injury ☐ Illness ☐ Other _____

To be released to:

☐ 701 Howe Avenue, Suite C5
Sacramento, CA 95825
Phone: (916) 972-1100
Fax: (916) 972-1615

☐ 2485 Sunrise Blvd. Suite A
Rancho Cordova, CA 95670
Phone: (916) 281-2251
Fax# (916) 281-2252

☐ 5255 Elkhorn Blvd.
Sacramento, CA 95842
Phone: (916) 334-1100
Fax: (916) 334-1105

☐ 2469 Rio Linda Blvd., Suite A
Sacramento, CA 95815
Phone: (916) 468-1100
Fax: (916) 333-3193

For the purpose of: _____

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

PROTECTED HEALTH INFORMATION

The medical information in this AUTHORIZATION is confidential and protected by both State and Federal Law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient of the intended recipient's agent, you are hereby notified that you have received this AUTHORIZATION in error, please notify us immediately at (916) 972-1100 and either destroy these documents or return the originals by mail. Thank you!