



**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 \_\_\_\_\_

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**

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**Allmed Sunrise**

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**Allmed Rio Linda**

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**Allmed Roseville**

729 Sunrise Ave, Suite 607  
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## **NOTICE OF 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 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 medical 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

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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 may include your 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.

**Health 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 or 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.

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#### 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.

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**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.

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**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 your 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 able 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.

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**PATIENT'S PAYMENT ARRANGEMENT FOR UNINSURED PATIENTS**

**PATIENT'S NAME:** \_\_\_\_\_

I hereby verify the following:

1. I have been informed of the nature of the services recommended for my condition(s) and of the usual fees charged by this office.
2. To the best of my knowledge, I am not eligible for or entitled to reimbursement for such serviced by any insurance plan, health care service plan, any governmental program (including Medicare and Medi-Cal), or any third party.
3. I am not financial able, at the present time, to pay the full amount of tile fees which would be charged by this office.
4. To enable me to receive services, I have been offered and have agreed to a special payment arrangement My payment will be in the following amount

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I agree to make these payments without any need for periodic bills or other reminders of payments due.

5. I agree to notify the office of any change in my health care coverage or financial situation.

This payment agreement does not apply to any services, which are covered by insurance, any health care service plan, any governmental program, or any third party claim.

The doctor's office reserves the right to discontinue this special payment arrangement upon reasonable notice to the patient

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**California Business and Professions Code §657**

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**FINANCIAL HARDSHIP PAYMENT AGREEMENT**

**PATIENT'S NAME:** \_\_\_\_\_

I hereby certify that I have been informed of the usual fees of this office for the examination, testing and treatment which has been recommended. I am unable to pay those fees at this time without substantial financial hardship.

To enable me to obtain services, I have agreed to the following payment arrangement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It is my responsibility to make these payments without any need for periodic bills or other reminders of payments due.

The health care provider's office reserves the right to discontinue this special payment arrangement upon reasonable notice to the patient

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_  
\_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_  
\_\_\_\_\_

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**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

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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!

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