**Patricia Guevara-Channell, M.D.**
**Daniel Channell, M.D.**
8008 Haven Ave, Suite 100
Rancho Cucamonga, CA 91730
(909) 483-1236 ● Fax (909) 483-1465

| Today's date: | Pt Acct: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one): Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address/PO Box: | | Social Security no.: | Home phone no.: ( ) |
|---|---|---|---|
| City: | State: | Zip Code: | Cell phone no.: ( ) |

| Driver's License: | Email Address: | Language: | Ethnicity & Race: |
|---|---|---|---|
| Occupation: | Employer: | | Employer phone no.: ( ) |

| Chose clinic because/Referred to clinic by (please check one box): | ❑ Dr. | ❑ Insurance Plan | ❑ Hospital |
|---|---|---|---|

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

| Other family members seen here: | |
|---|---|

## PAYER/INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
|---|---|---|---|

Is this person a patient here? ❑ Yes ❑ No

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

| Please indicate primary insurance: | Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative: | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Channell Family medical Group or insurance company to release any information required to process my claims.
La información anterior es verdadera a lo mejor de mi conocimiento. Autorizo a mis beneficios del seguro se pagará directamente al médico. Entiendo que soy financieramente responsable de cualquier balance también autorizo a Channell Family Medical Group o seguro empresa para liberar toda la información necesaria para procesar mis reclamos.

| *Patient/Guardian signature* | *Date* |
|---|---|

**Office Policy**

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Office hours.** Our office is open Monday to Friday, 9:00am to 5:00pm. We are closed for lunch from 12:00pm to 2:00pm. We are closed for all major holidays; please call our offices for exact dates and times. **Same day appointments.** If you are sick and need to be seen, please call our office as soon as you start to feel sick, and we will try to work you in. Please be aware this is considered a sick visit and we will not do any preventive services at the same visit.

2. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If you are insured by a plan with which we are contracted, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If you have multiple insurance coverages, we are required by our contract to bill your primary first, secondary second, etc….

3. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. **This arrangement is part of your contract with your insurance company.** Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. **Non-covered services.** Please be aware that some-and perhaps all-of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit. Please be aware for a TB test the fee is $35.00, we do not bill any insurances for this charge.

   Initial: __________

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim. **Claim submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Please be aware our contract with your insurance company does have timely submission requirements. If you do not notify us within those requirements, you will be responsible for the visit.

6. **Self-pay patients.** Please be aware before your visit, we require a deposit for all self-pay patients: New Patients-$200.00 for Patricia Guevara-Channell, M.D. and $200.00 for Daniel Channell, M.D... For establish patients-$100.00 for Patricia Guevara-Channell, M.D. and $100.00 for Daniel Channell, M.D., that will be collected by the receptionist upon check in. Based on the complexity of the visit, your account will be reconciled, after you see the doctor, any balance due will be collected then. On an average, plan to spend approximately 20-30 minutes with the doctor for a new patient and 10-15 minutes for an established patient.

   Initial: __________

7. **Office Visits/Physicals/Procedures.** Office visits are an evaluation and management of a medical condition/illness/injury. Physicals (Well Exams/Well Woman Exams/Well Child Exams) are visits for **prevention** of medical conditions/illness/injury. Our office does not provide service for more than one type of treatment per day. **Sport/camp/work physicals.** Please be aware, most insurance companies do not cover physicals for those reasons. We will bill your insurance but balance will be responsibility of the patient.

8. **Account Credits.** Our office will not issue a refund for a credit less than $25.00, unless requested by the patient. We will hold the credit on your account for future services. Accounts will be audited within 30 days of payment, once all visits have been finalized. All refund checks must be picked up in person by the patient and signed for once received. **Finance fee.** After 30 days of a balance due, finance charge of 18% per year will accrue. **Past due accounts.** If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer collection of the balance to a collection agency/lawyer, you agree to pay all fees, which we incur, plus all court costs. As of 1/1/2018 we no longer accept checks as a form of payment.

   Initial: ___________

9. **Missed appointments.** Our policy is to charge **$30.00** for missed appointments for establish patients not canceled within 24 hours before your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

   Initial: ___________

10. **Form charge.** Our policy is to charge for form completion based on length and time taken for the form. Fees *start* at $20. The patient will be required to pick up the completed form. Please be aware forms will not be accepted until paid for and it may take up to 7 working days to complete the forms.

11. **Medical records.** We will need your written authorization to send copies of our medical records to yourself and/or another physician. This service will be provided at no charge to send records to another physician; however, should you prefer to obtain your records directly, a processing and preparation fee of $35.00 must be collected before we can release your records.

12. **Phone call charge.** Current medical guidelines permit for patients to be charged for phone calls and emails from patient to physician. Fee based on time and starts at $99.

13. **Phone Messages.** Please allow 24 hours for all non-urgent phone messages. Urgent messages will be answered immediately. **Results.** Please allow **7 working days** before calling our office to inquire about results. **Medication Refills.** Please call your pharmacy for all refill requests. Please allow **5 working days** to process a refill request. All patients with chronic conditions or on Hormone Replacement Therapy will need to see the physician every **3 months**. And prescriptions will only be given for **3 months** at a time.

14. **Acceptance of financial responsibility.** Under certain circumstance your insurance carrier may not consider specific healthcare treatments to be of a medical necessity and/ or classified as experimental in nature. On these occasions it may be necessary to hold the patient financially responsible for non-covered procedures and the cost may be extended to the patient. Please be aware that some services may not be payable by your insurance carrier and may be billed directly to you. By signing and initialing you are acknowledging that we have made you aware of the possibility of being financially responsible for said services. The staff is available to answer questions regarding which services may be billed.

    Initial: ___________

Please do not bring children to our office, unless they are the patient to be seen. As adorable as children are we unfortunately have limited waiting area space. If you must bring children, please make sure there is a responsible adult to watch them at all times.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. By signing this form, you give Channell Family Medical Group permission to use any information in your chart to contact you for any reason including to collect a debt. Thank you for understanding our office policy. Please let us know if you have any questions or concerns.

**I have read and understand the payment policy and agree to abide by its guidelines:**

________________________________________ ______________________________

**Signature of patient or responsible party** **Date**

## PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

**Patient Profile Picture Consent:**

I hereby authorize Channell Family Medical Group, and/or representative(s) of the practice, to take a photograph of myself for my medical chart so that they can identify me easily. This image will not be used or released in any other way other than mentioned above. The use of my profile photo is limited identification of my person.

Signature: ________________________ Date: __________________________ Witness: ________________________

## Patient Partnership Plan

Dear Patient,

Welcome to our practice! We intend to provide you with the best care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and our practice. As our "partner in health", we ask you to help us in the following ways:

**Schedule Visits With My Doctor For Routine Physical Exams And Other Recommended Health Screenings**
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and discuss these health screenings.

**Keep Follow-Up Appointments and Reschedule Missed Appointments**
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to

treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, Prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

**Call the Office When I Do Not Hear the Results of Labs and Other Tests**

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my results.

**Inform My Doctor if I decide Not to Follow His or Her Treatment Plan**

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health condition, please ask.

Name:________________________________ Signature:____________________ Date: ____________

## NOTICE OF PRIVACY PRACTICES

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that Requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you the significant new rights to understand and control how your health information is used. "HIPPA" provided penalties for covered entities that misuse personal health information.**

**We may use and disclose your medical records only for each of the following purposes:**

1. **TREATMENT** meaning providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical exam.
2. **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. **HEALTH CARE OPERATIONS** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute do-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
   Any other uses and disclosure will be made only with your written authorization. You may revoke Such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions on rely on your authorization.
   You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person, identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction we must abide by it unless you agree in writing to remove it.

2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.

3. The right to inspect and copy your health information

4. The right to amend your protected health information

5. The right to receive an accounting disclosure of protected health information

6. The right to obtain a paper copy of this notice from us upon request

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of April 11, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notices provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.
For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office of Civil Right
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257

By my signature below, I acknowledge that I have thoroughly read and been offered a copy of the Notice of Privacy Practices from the medical office of **Channell Family Medical Group.**

**Patient's Name:**_______________________________________________

**Patient Signature:** ______________________________________________

**Date:** ________________

**HIPAA CONSENT**
**Patient Record of Disclosures**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

**I wish to be contacted in the following manner (check all that apply):**

___ Home Telephone
___ OK to leave a message with details
___ Leave message with call-back number only

___ Work Telephone ___________________
___ OK to leave a message with details
___ Leave message with call-back number only

___ Cell Telephone ___________________
___ OK to leave a message with details
___ Leave message with call-back number only

___ Written Communication
___ OK to mail to my home address
___ OK to mail to my work/office address
___ OK to fax to this number: ____________________

___Send email with details

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

Patient Name (Print) _________________________ Birthdate: _________________

Signature: __________________________________ Date: _______________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record Note: Uses and disclosures for Treatment Records, Payment Information and Healthcare Operations may be permitted without prior consent in an emergency.

**Authorization for Disclosure**

| To Whom | Relationship |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Comprehensive Health History Form**

How would you rate your general health? ◻ Excellent ◻ Good ◻ Fair ◻ Poor

Main reason for today's visit: ___________________________________________________________

Other concerns: _________________________________________________________________

Please circle any areas you've had new health problems with over the last six months:

| HEAD | BREATHING | BOWELS | SKINS | ALCOHOL ABUSE |
|---|---|---|---|---|
| NECK | CHEST | URINATION | BALANCE | DRUG ABUSE |
| EARS | HEARTBEAT | SEXUAL FUNCTION | NUMBNESS | FATIGUE |
| EYES | CIRCULATION | BONES/JOINTS | WEAKNESS | FEVER |
| NOSE | ABDOMEN | PAIN | SPINE | MOOD |
| THROAT | DIGESTION | HANDS/FEET | THOUGHTS | SLEEP DISORDER |
| EATING DISORDER | FAMILY PROBLEMS | WORK PROBLEMS | WEIGHTLOSS | WEIGHT GAIN |

Give details of the items marked:

_____________________________________________________________________________

_____________________________________________________________________________

**OB/GYN HISTORY (WOMEN ONLY)**

What type of birth control do you use? ______________

How many days from the start of your period to the start of your next? __________

How many days do you bleed? ______________

Are they (circle all that apple): Normal? / Light? / Heavy? / With Clots?

Number of pregnancies: _________ Elective Terminations: _______________ Miscarriages: ____________

Vaginal Deliveries: ____________ Cesarean Deliveries: ___________________

# of Children: ___________ Ages: _______/ _______/_______/_______/_______/_______/

Date of last Pap smear: _____________ Normal/ Abnormal? (Circle one)

Date of last breast exam: ______________

Date of last mammogram: _____________ Facility/Location: _________________________________

Breast Implants? YES / NO

Breast or ovarian cancer in immediate family? YES / NO

Have you been through the change (started menopause)? YES / NO

Provider comments:

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Provider Signature: _______________________________________ Date: _____________________________________

**Medical History**

Please list any allergies to medications and what occurs when you take these medications:

Please list your current medications and dosages:

Please list any ongoing conditions for which you require treatment:

**Surgical History**
Please list your surgeries and date performed:

**Family Medical History**
Please mark any diseases which run in your immediate family (blood relations):

| Epilepsy | Heart Disease | Alcoholism | Asthma |
|---|---|---|---|
| Bleeding Disorders | High Blood Pressure | Tuberculosis | Cancer |
| Diabetes | Stroke | Sickle Cell Trait | Other: |

Give details (which family members; living? Deceased?

**Social History**
Marital Status: ____________________ Occupation: ____________________

Have you been exposed to the following?
□ IV Drugs □ Multiple Sex Partners □ Or Had a Blood Transfusion

Do you use the following? If so how much and how often?
□ Tobacco ______________________________________ □ Alcohol ________________________________________
□ Street Drugs ___________________________________ □ Caffeine _______________________________________

What is the primary language spoken in your household? ___________________________________
Do you exercise and how often? __________________________
Have you received any of the following? What year?
□ Tetanus __________ □ Measles / Mumps / Rubella _________ □ Pneumonia _________
□ Influenza _________
When was your last tuberculosis skin test? _______________________