Channell Family Medical Group
Patricia Guevara-Channel|, MD
Daniel B. Channell, MD
8008 Haven Avenue, Suite 100
Rancho Cucamonga, California 91730
(909) 483-1236 • Fax (909) 483-1465

COPAYS, DEDUCTIBLES AND SHARED COST WILL BE COLLECTED AT APPT.
$30.00 NO SHOW/RESCHEDULE FEE

REGISTRATION FORM

ALL INFORMATION IS CONFIDENTIAL AND IS ONLY RELEASED WITH YOUR CONSENT

Section I: **Patient Information** **Date______________**

Name/Nombre:______________________________ Patient's Account #_________ Category_________
Address/Domicilio:____
City/Ciudad:___________________ State/Estado:________ Zip/Zona Postal_______
Phone (______)_________________ Work Phone (_____) ________________ Cell Phone (______)____________________
DOB/Fecha de Nacimiento:_______________ Social Security Number:________________ Sex ☐ M ☐ F
Check Appropriate Box: ☐ Minor/Menor ☐ Single/soltero ☐ Married/Casado ☐ Widowed/Viudo ☐ Separated/Separado ☐ Divorced/Divorciado
Ethnicity/Grupo Etnico__________________ D License#/Licencia de Manejar _______________________
Occupation/Ocupacion:_________________________ Employer/Empleador:____
Work Phone (___) ___________________ __ Whom may we thank for referring you? ______________________________
Email Address______________________________________ Primary Doctor__________________________________

Person to contact in case of emergency_____________________________________ Phone (______)________________

Section II **Responsible Party**

Relationship to Patient: ☐ Self /Usted ☐ Spouse/Esposo ☐ Parent/Padres ☐ Other/Otro
Name:_________________________________ Relationship to Patient/Relacion con el Paciente: ______________________
DOB/Fecha de Nacimiento:_________________________ SSN#_____________________________
Address:____
City:__________________________________ State:__________ Zip:_____________ Phone: (____)_____________________
Employer_________________________ Work Phone (____)__________________

Section III **Insurance Information**

Name of Insured_________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City__________________State:________Zip ___________
Insurance Company_____________________________ Group #______________________ ID#_________________________
Ins Co Address:____ Ins Co. Phone:_____________________________

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured_________________________________DOB_______________Relationship to Patient ________________
SSN#:________________________ Name of Employer:_______________________ Work Phone: (____)_______________
Address of Employer:___________________________________City__________________State:________Zip ___________
Insurance Company___________________________ Group #______________________ ID#_________________________
Ins Co Address:____ Ins Co. Phone:_____________________________

I authorize payment of medical benefits be made directly to the physician provider for services./Yo autorizo page de beneficios medicos directamente al doctor por sus servicios I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported./ Yo autorizo a cualquier compañia de seguros, organizacion, empleador, hospital, doctor, farmaceutico, para obtener informacion pertinent a estos servicios y cobros.

Date/Fecha _____________ SIGNED (Insured or Authorized) Firma del Paciente_______________________________________

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Payment 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, sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, 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 coverage, we are required by our contract to bill your primary first, secondary second, etc….

2. **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.

3. **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. We do require a fee of $35.00 be paid prior to you receiving a TB test. Once your insurance has processed the claim, you will be refunded accordingly to the EOB.

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.

5. **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.

6. **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.

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7. **Self-pay patients.** Please be aware our current fee for a new patient is $175.00; with an average time spent with the doctor is 30-40 minutes. Our current fee for an established patient is $75.00; with an average time spent with the doctor is 15-20 minutes. If you are an established patient and would like more time with the doctor, you may pay for 2 appointments for a fee of $150.00; with an average time spent with the doctor is 30-40 minutes. Please notify the receptionist when you are scheduling your appointment.

8. **Non-payment.** If your account is over 90 days past due. You will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

9. **Missed appointments.** Our policy is to charge **$30.00** for missed appointments 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.

10. **Form charge.** Our policy is to charge for form completion as follows:
    Medical Records to a patient $35.00
    EDD, Physical Exams (sports/school/work) $15.00
    FMLA $20.00, with Medical Records $30.00
    DMV $45.00
    Please be aware forms will not be accepted until paid for and it may take up to 14 days to complete the forms.

11. **Phone Messages.** Please allow 24 hours for all non-urgent phone messages. Urgent messages will be answered immediately.

12. **Results.** Please allow 7 working days before calling our office to inquiry about results.

13. **Medication Refills.** Please call your pharmacy for all refill requests. Please allow 5 working days for all refill request.

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 payment 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**

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ELIGIBILITY GUARANTEE FORM

This form is to be used for patients claiming that they are eligible with their Health Plan at the time of service. Have the member sign this form if they are not listed on the eligibility list, do not have a permanent ID card, or eligibility cannot be verified by calling the health plan.

Member Name: ____

Health Plan: ____

Effective Date: ____

Subscriber ID#: ____

I hereby certify that I am eligible for coverage as of the date indicated above with the health plan.

I understand eligibility with the Health Plan cannot be verified at this time. I understand that it I am not eligible under the terms of my employers/Health Plan agreement, I am liable for all of the billed charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 60 days of receiving a bill from my physician or his/her authorized agent. I understand that failure to pay any amounts owed by me may result in my account being placed in collections.

____
Signature of Member/Guardian

____
Office Personnel

____
Date

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Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. 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 and 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 to 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 the 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 Recommended 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 and concerns you may have. If you need more information about your health or condition, Please ask.

______________________________	_____________________________	______________
Print Name	Patient Signature	Date

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AUTHORIZATION AND CONSENT TO PHOTOGRAPH

The Undersigned hereby authorizes the Channell Family Medical Group and the attending physician to photograph or permit other CFMG staff to photograph, while under the care of the Channell Family Medical Group

____

(Patients Name)

Patient Signature: ____________________________________ Date: ____________________________

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NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that 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 give you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" 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 means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
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 relying on your authorization.

You have the following rights with respect to you 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 at alternative locations.
3) The right to inspect and copy your protected health information
4) The right to amend your protected health information
5) The right to receive an accounting of 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 notice 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 Avenue, S.W.
Washington, D.C. 20201
(202) 6 1 9-0257

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 (please print):____

Patient's Signature: ____ Date: __________________________

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PATIENT RECORD OF DISCLOSURES - HIPPA PRIVACY ACT

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

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

Home Telephone ___________________

- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone ________________________

- ☐ Leave message with detailed information
- ☐ Leave message on my work voicemail only
- ☐ Leave message with call-back number only

Written Communication

- ☐ Mail to my home address
- ☐Mail to my work/office address

____
Address City/St/Zip

- ☐ Fax to this number ___________

Email___________________________

- ☐ Home Send email message with detailed information
- ☐ Work Send email message with detailed information

____ Patient Signature

_____________________________ Date

____ Print Name

_____________________________ Birthrate

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 protected health information disclosures. Information provided below, of completed transactions will constitute an adequate record.

Record of Disclosures of Protected Health Information

Date	Disclosure to whom/Address/Fax/Email	Description & Purpose	Sent By

CHANNELL FAMILY MEDICAL GROUP

Patricia Guevara-Channell, M.D. Daniel B. Channell, M.D.

COMPREHENSIVE HEALTH HISTORY

DATE: ____________

NAME: ______________________________________ AGE: _____ DOB: ____________

REVIEW OF SYSTEMS

Please mark any areas in which you had new health problems over the last six months:

☐ Head ☐ Neck	☐ Breathing ☐ Chest	☐ Bowels ☐ Urination	☐ Skin ☐ Balance	☐ Alcohol Abuse ☐ 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 Disorders	☐ Family Problems	☐ Work Problems	☐ Weight Loss	

GIVE DETAILS OF ITEMS MARKED:

____
____
____
____

OB/GYN HISTORY (FOR WOMEN ONLY)

WHAT KIND OF BIRTH CONTROL DO YOU USE? ____

REGARDING YOUR MENSES, IF ANY:

HOW MANY DAYS FROM THE START OF YOUR PERIOD TO THE START OF YOUR NEXT PERIOD? __________

HOW MANY DAYS DO YOU BLEED? __________

ARE THEY (CIRCLE ALL THAT APPLY): NORMAL? / LIGHT? / HEAVY? / WITH CLOTS?

NUMBER OF PREGNANCIES: _______ ELECTIVE TERMINATIONS: _______ MISCARRIAGES: _______

VAGINAL DELIVERIES: _________ CESAREAN DELIVERIES: _________
LIVING 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: ___________________________

CHANNELL FAMILY MEDICAL GROUP

Patricia Guevara-Channell, M.D. Daniel B. Channell, M.D.

Comprehensive Health History

Date: ___________

NAME: ____________________________________ AGE: _____ DOB: ____________

MEDICAL HISTORY

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY?

____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS AND WHAT OCCURS WHEN YOU TAKE THESE MEDICATIONS:

____________________________/ ____________________________/ ____________________________
____________________________/ ____________________________/ ____________________________

PLEASE LIST YOUR 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 SEXUAL PARTNERS ☐ OR HAD A BLOOD TRANSFUSION

DO YOU USE THE FOLLOWING? IF SO, HOW MUCH AND HOW OFTEN?

☐ TOBACCO ____________________________________ ☐ ALCOHOL ____________________________________

☐ STREET DRUGS (NAME) ________________________ ☐ CAFFEINE ____________________________________

WHAT IS THE PRIMARY LANGUAGE SPOKEN IN YOUR HOUSEHOLD?

____

WHAT EXERCISE DO YOU GET AND HOW OFTEN?

____

HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS? WHAT YEAR?

☐ TETANUS ___________ ☐ MEASLES/MUMPS/RUBELLA ___________ ☐ PNEUMONIA ___________ ☐ INFLUENZA ___________

WHEN WAS YOUR LAST TUBERCULOSIS SKIN TEST__________________