Welcome Letter

Compassionate Family Care would like to take a moment and thank you for choosing our practice as your primary care provider.

Enclosed is a registration packet for you to complete and return to our office prior to being scheduled for your first appointment. Your medical records are strictly confidential and the Health Information Portability and Accountability Act (HIPAA) restrict us from releasing or obtaining any information without your written permission. Therefore, inside each packet is a medical release of records form. This will allow us time to obtain your medical records from your prior medical provider(s) and treatment centers. Please ask our staff if you have any questions about any forms within the packet. Upon completion of these forms, our dedicated providers will review your registration information and will contact you to schedule your consultation.

In order to provide you and your provider adequate time to assess your prior medical history and identify your medical needs; your first consultation has specific time slot(s). We understand that in today's busy world circumstances arise that are beyond your control. In these situations we request that you extend us the courtesy of providing our office with a 24-hour notice if you need to cancel or re-schedule your appointment. This allows us to continue to operate efficiently and provide quality care to all of our patients in need. It is our policy that habitually missed appointments without the proper notification are grounds for dismissal from the practice. A missed appointment fee of $80.00 will be charged for all appointments not cancelled or rescheduled within 24-hours of your scheduled appointment time.

Please plan to arrive ten (10) to fifteen (15) minutes prior to your scheduled appointment and bring your health insurance identification card as well as a photo I.D. This allows time for our staff to properly check you in and update your medical file as needed. We ask that you please bring a complete list of all your medications, as well as your medication bottles with you to your first appointment so that your provider can verify your treatment plan and provide you with the proper care.

If you need a medication refill; please contact your pharmacy directly at least two days prior to your last dose of medication. Response times vary and may take 24-48 hours or more from the time your pharmacy has requested a refill until the time the provider makes a determination. All narcotic and other controlled substance prescriptions require a monthly visit and must be completed by the provider on a unique serialized prescription form. If your medication refills are completed by mail, it is your responsibility to arrange delivery of your medications and/or refill prescriptions. Medication refill authorizations and requests will not be mailed from our office nor can we fax the request directly to you. Please allow 5-7 working days for the completion of any forms, letters, or prior authorizations.

It is our policy that any patient of Compassionate Family Care, requiring and obtaining medical testing or treatment outside of the network will be required to review their results with one of our providers in person. Failure to follow the medical instructions reviewed and given to you by your provider can result in your dismissal from the practice. Any patient who voluntarily discharges themselves from the hospital, against medical advice, will be dismissed from the practice.

It is your responsibility to ensure that our office has accurate and current insurance and billing information in your record. If a medical claim is unsuccessful because of inaccurate insurance and/or billing information, you will be responsible for the balance. As part of our contract with the insurance companies we are legally required by the terms of the contract to collect any and all co-pays or deductibles from you at the time of service. We do ask that you be prepared to pay your co-pay at the time of check-in and your account may be assessed a fee or your appointment rescheduled if payment is not received. In an effort to serve you best we offer multiple forms of payments.

For those patients without insurance; we offer a ten (10) percent discount for those services paid in full at the time of the visit. If you have insurance, we will bill your insurance carrier directly. Balances are due within thirty (30) days of the Billing Statement date. We will accept all authorized payment arrangements from our billing department within (30) days of your visit. Any unpaid balances greater than ninety (90) days, without a prior authorized payment arrangement on file, will be directed to our collections agency for repayment.

It is our mission to provide you with the highest quality of care and service at Compassionate Family Care. If you have any questions, please contact our office and our staff will be happy to assist you. Thank you for choosing Compassionate Family Care and we look forward to seeing you at your next appointment.

Compassionate Family Care

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ 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 Race:

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

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 Pharmacy:

Other family members seen here:

Primary Language:

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.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ Key Medical Group ☐ Blue Cross ☐ Medicare ☐ Nationwide ☐ Blue Shield PPO ☐ Health Net ☐ Tri Care ☐ United Health ☐ Foundation For Medical Care ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

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

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.: Subscriber's Birth date: / /

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): 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 Compassionate Family Care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

MEDICAL HISTORY FORM

Date: ________________

Previous Doctor: ___________________________________Phone:__________________

Reason for switching care: ____

____

Patient's Name: ____

Allergies: ____

____

Are you currently taking any medications? Y or N If yes please list them below.

Please list your medications including the strength and how often you take it:

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Medication__________________________Dosage_______________Doctor______________
Directions__________________________Reason for taking___________________________

Patient's Past History: Mark the boxes to the right either yes or no for the following question: Do you have or have you ever had any of the following:

	Yes	No
Allergic Rhinitis	( )	( )
Asthma	( )	( )
Cancer/Tumors	( )	( )
Congestive Heart Failure	( )	( )
COPD	( )	( )
Depression	( )	( )
Diabetes	( )	( )
Fibromyalgia	( )	( )
Glaucoma	( )	( )
High Cholesterol	( )	( )
High Blood Pressure (hypertension)	( )	( )
Migraine	( )	( )
Multiple Sclerosis	( )	( )
Myocardial Infarction (heart attack)	( )	( )

	Yes	No
Osteoporosis	( )	( )
Prostate Conditions	( )	( )
Pulmonary Embolism	( )	( )
Seizure Disorder	( )	( )
Sleep Apnea	( )	( )
Stroke	( )	( )
Thyroid Disorder	( )	( )

WOMEN ONLY

Last menstrual period? _____

Birth control? _____

At what age did your menstrual period begin?___

Pregnancy/abortion/miscarriage	( )	( )

Past Surgical History:

List dates of all operations, surgeries, injuries, and illness that required hospitalization:

_____

_____

_____

_____

_____

_____

Family History:

List family members: (mother, father, brothers, sisters, and grandparents, etc) - ages and health status (if deceased write their age at the time of their death and the cause). List allergies and any conditions or diseases they may have or have had, such as asthma, arthritis, tuberculosis, diabetes, cancer, heart disease, hypertension, kidney disease, mental illness, depression, or any other health problems that you know of in your family.

_____

_____

_____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

Compassionate Family Care

(559) 713-1101

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

Consent to Photograph

I consent to be photographed by Dr. Soloniuk-Tays.

Patient Name _____

I refuse to consent to be photographed by Dr. Soloniuk-Tays.

Patient Name_____

Patient Signature _____Date_____

The photograph will be taken from the shoulders and above.

Patients that refuse to be photographed will not be accepted as patients to Compassionate Family Care. The purpose of the photograph is to provide facial recognition to your sensitive medical records and ensure your privacy.

TO: PATIENTS OF DR. SOLONIUK-TAYS
RE: **FEE FOR MISSED APPOINTMENTS**
DATE: JULY, 2005

Unfortunately the time has come for Dr. Soloniuk-Tays to begin charging patients for missed appointments. We are currently scheduling many types of medical appointments several weeks or months in advance because of our increased number of patients. When a patient does not keep an appointment or does not call to cancel the appointment within 24 hours prior to the scheduled time, we are denied the opportunity to fill that appointment slot with someone from our waiting list who really does need to be seen.

Dr. Soloniuk-Tays policy of charging for missed appointments if not notified at least 24 hours in advance is now referenced on your appointment card. The fee for the first missed appointment is $30.00. For all subsequent missed appointments a full exam fee of $81.00 will be charged. These fees are not covered by your insurance.

Please call our office at 713-1101 and advise us if you need to cancel or reschedule your appointment at least one day in advance. If after hours, leave a message with the answering service and the service will give us a message the next business day as to the time and date you called.

IT IS VERY IMPORTANT THAT YOU CALL OUR OFFICE AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TIME TO CANCEL OR RESCHEDULE.

If you have any questions, please don't hesitate to call our office. The number is 713-1101.

_____ _____

Signature Date

306 N Conyer St Visalia, CA 93291
Phone (559) 713-1101 Fax (559) 713-1121

Gaylene J Soloniuk-Tays MD

NOTICE REGARDING INAPPROPRIATE BEHAVIOR

As a patient of Compassionate Family Care you have a responsibility to remain respectful when interacting with the physician, nurse practitioners, and staff. Unfortunately there seems to be an unacceptable trend of patients or their family members verbally abusing the office staff.

I have dedicated and hard working employees who try their best to assure that your medical care and insurance needs are handled in a professional and timely fashion. If you have questions regarding your health care or billing we will do our best to help resolve the issue. Often my staff becomes the target of some individual's anger, which can quickly escalate into abuse.

The intent of this document is to give you prior notice that I will not tolerate abusive or inappropriate behavior of any sort to my staff members or myself. Such behavior will be grounds for immediate termination of our physician/patient relationship and dismissal from my practice. Your signature acknowledges receipt of this information.

Sincerely,

Gaylene J Soloniuk-Tays MD

Patient Signature: _____ **Date:** _____

Notice of Privacy Practices
Compassionate Family Care
(559) 713-1101

Effective Date: September 23, 2013

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

8. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

9. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

10. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

11. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

13. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision. You have the right to restrict certain disclosures Protected Health Information to a health plan when the patient pays out of pocket and in full for a health care item or service.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. You have the right to obtain a copy of your Protected Health Information in electronic format if the covered entity maintains the Protected Heath Information electronically.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

7. Marketing. We will not sell your Protected Health Information for marketing purposes and you have the right to opt out of fundraising solicitations.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

You will not be penalized for filing a complaint. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg. 200 Independence Avenue, S.W. Room 509F HHH Building, Washington,DC 20201