PRIMARY HEALTH CARE MEDICAL GROUP

PATIENT INFORMATION

DATE: _____
ACCOUNT#: _____

PLEASE PRINT

Last Name:	First Name:	Middle Initial:

Age: Date of Birth: Social Security:	Street Address: APT #: P.O. BOX: City: State: Zip code:	**SEX ASSIGNED AT BIRTH:** ☐ Female ☐ Male ☐ Intersex ☐ Other	**LANGUAGE PREFERENCE:** ☐ English ☐ Spanish ☐ Other

PRIMARY TELPHONE#: **ALTERNATE TELEPHONE#:**	**EMPLOYER:** **TELEPHONE**:

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner ☐ *Minor	**GENDER IDENTITY:** ☐ Female ☐ Male ☐ Intersex ☐ Other ☐ Prefer Not to Say	**PRONOUNS:** ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other

TRANSGENDER: ☐ **YES** ☐ **NO** Transgender ☐ Woman ☐ Man ☐ Transgender Woman/Trans Feminine ☐ Transgender Man/Trans Masculine ☐ Non-Binary **GENDERQUEER/GENDER FLUID** ☐ Two Spirit ☐ Prefer to self-describe_____ ☐ Prefer not to say	**RACE:** (Circle)White, Black, African American, Hispanic, American Indian or Alaska Native, Asian, None Reported, **Another Race**: **ETHNICITY** (Circle): Hispanic/Non-Hispanic/Refuse to Report

EMAIL: ☐ **I do not have one**	**EMERGENCY CONTACT**: NAME: TELEPHONE:

PRIMARY PHARMACY:	**Who referred you?**

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO THE RECEPTIONIST

FINANCIAL RESPONSIBILITY PARTY ☐ PATIENT IS A MINOR-PARENT INFORMATION	Last Name:	First Name:
	Social Security: Relationship to Patient:	Date of Birth:

Address:	City:	State:	Zip Code:

Home Phone:	Business/Cell Phone:	Employer:	Address:

FINANCIAL AGREEMENT

- I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE-NAMED PATIENT.
- I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE.
- I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES RENDERED BY THE PHYSICIAN AND AUTHORIZE TRANSFER OF ALL UNPAID AMOUNTS TO MY VISA/MASTERCARD AFTER 120 DAYS FROM THE DATE OF SERVICE.
- I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT THE TIME OF SERVICE UNLESS OTHER DEFINITE FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR TO TREATMENT.
- I FURTHER AUTHORIZE AND REQUEST THAT INSURANCE PAYMENTS BE MADE DIRECTLY TO **PRIMARY HEALTHCARE MEDICAL GROUP.**

Signature: **INCOMPLETE FORMS WIILL NOT BE ACCEPTED** **Date:**

Lorenzo H. Suarez, M.D., A.A.F.P.
Family Practice

OPEN PAYMENT DATABASE

Primary Healthcare Medical Group is providing notification to you in reference to Open Payments database. It is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://onpaymentsdata.cms.gov

I acknowledge that I am in receipt of the Open Payment Database notification.

Patient Name: _____ Date of Birth _____

Date: _____

OPEN PAYMENT DATABASE

Primary Healthcare Medical Group le envía una notificación en referencia a la base de datos Open Payments, que es una herramienta federal que se utiliza para buscar pagos realizados por compañías de medicamentos, dispositivos de medicamentos, y hospitales universitarios. Se puede encontrar en https://onpaymentsdata.cms.gov

Reconozco que he recibido la notificación de Open Payment Database.

Nombre del Paciente: _____Fecha De Nacimiento: _____

Fecha: _____

Notice of Privacy Practices & Patient Authorization to Use or Disclose Protected Health Information

Effective Date: _____

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, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information.

Primary Healthcare Medical Group is required by law to obtain your written consent before the use or disclosure to others of your protected healthcare information for purposes providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

Primary Healthcare Medical Group may be required or permitted by law to use and disclose your protected healthcare information for other purposes without your consent or authorization.

As a patient of **Primary Healthcare Medical Group** you have important rights to inspect and copy your protected healthcare information in our possession, amend or correct that information, obtain and account of our disclosures of your protected healthcare information, request that we communicate with you confidentially, request that we restrict certain use or disclosure of you protected healthcare information, and have the right to submit a complaint if you believe or suspect there has been improper use or disclosure of your healthcare information according to your rights.

Primary Healthcare Medical Group has a complete and thorough Notice of Privacy Practices available at your request. This notice better explains in full your rights and our obligations under the law. The date located at the top left corner indicates the date of our most up to date and current Notice of Privacy Practices.

As a patient of **Primary Healthcare Medical Group**, you have the right to obtain a copy of our most up to date and current Notice of Privacy Practices. This copy will be provided to you in hard copy at your request.

Primary Healthcare Medical Group prides itself in assuring patients understand in full any policies or practices implemented at this facility. Should you have any questions regarding the Notice of Privacy Practices do not hesitate to contact us by phone or in person. We will be happy to answer any questions or concerns you may have.

I hereby authorize **Primary Healthcare Medical Group** to use or disclose my protected health information to:

_____

_____

_____

Name or class of person(s) other than current employees or owner(s)

Patient Signature: _____ **Date:** _____

Signature of Practice Representative: _____ **Date:** _____

Lorenzo H. Suarez, M.D., A.A.F.P.
Family Practice

ACKNOWLEDGEMENT

I received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I have received the Joint Notice of Privacy Practices and I have been provided an opportunity to review it.

Please check the box that is applicable:

☐ **NO** I do NOT authorize ***Primary Healthcare Medical Group*** to disclose any/or all information to any/all affiliates of Care Quality, UCSD, Commonwell, Prism, Aledade ACO or Manifest.

Printed Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

ACUSE DE RECIBO

Recibí el aviso de prácticas de privacidad y he recibido la oportunidad de revisarlo.

He recibido la notificación conjunta de prácticas de privacidad y he recibido la oportunidad de revisarlo.

Por favor de marcar la caja si es aplicable:

☐ **NO** autorizo ***Primary Care Healthcare Medical Group*** a revelar alguna / o toda la información a los afiliados cualquier/todo de Care Quality, UCSD, Commonwell, Prism, Aledade ACO y Manifest

Nombre del Paciente: _____ **Fecha de Nacimiento:** _____

Firma: _____ **Fecha:** _____

Lorenzo H. Suarez, M.D, A.A.F.P.
Family Practice

Continuity of Care Consent Form

Dear Patients,

Doctor Lorenzo H. Suarez is honored that you have chosen him for your health care needs. He is a Board-Certified Family Physician who is dedicated to providing superior medical care to you and your family. The following information is designed to help you become more acquainted with his practice. Please be advised that you may choose to see Family Nurse Practioners: Mario Aguirre, Manuel Barriga, or Physician Assistant: Alba Gutierrez. However, for continuity of care you are required to see either Dr. Lorenzo H. Suarez, Dr. John A. Friedline, or Dr. Owais Ahmad at least once a year.

This document has been fully explained and I have read and understood the context and the explanation received.

Patient Name/Date of Birth: _____

Signature/Date: _____

Estimados Pacientes,

El doctor Lorenzo H. Suarez esta honorado de que lo haya elegido para sus necesidades de atención médica. Es un médico de familia certificado por la junta que se dedica a brindarle atención médica superior a usted y su familia. La siguiente información está diseñada para ayudarle a familiarizarse con su práctica. Tenga en cuenta, su usted desea puede elegir a ver a los enfermeros practicantes familiares: Mario Aguirre, Manuel Barriga, o Alba Gutierrez, asistente médico. Sin embargo, es requerido para la continuidad de la atención ver al Dr. Lorenzo H. Suarez, Dr. John A. Friedline, o Dr. Owais Ahmad por lo menos una vez al año.

Este documento ha sido completamente explicado y he leído y entendido el contexto y la explicación recibida

Nombre del Paciente/Fecha de Nacimiento: _____

Firma/Fecha**:** _____

CLINICAL HISTORY AND PHYSICAL FORM

Date: _____

Patient Information

Patients Name: _____ Age: _____ Date of Birth: ____/____/_____

Sex Assigned at Birth: □ Female □ Male □ Intersex □ Other

Previous Family Physician: _____Referring Physician: _____

Occupation: _____ For How Long? _____

Medical History:

(Please check all conditions that you have or have had)

□ **None**	□ **Anxiety or Depression**	□ **Environmental Allergies**
□ **High Blood Pressure**	□ **Bipolar Disorder**	□ **Measles, Mumps or Rubella**
□ **Heart Disease**	□ **Other Mental Disorders**	□ **Shingles**
□ **Coronary Artery Disease**	□ **Insomnia**	□ **Arthritis (Type): _____**
□ **Stroke/TIA**	□ **Fainting/Dizzy Spells**	□ **Osteopenia/Osteoporosis**
□ **High Cholesterol**	□ **Seizures**	□ **Broken Bones or Fractures**
□ **Kidney Disease**	□ **Asthma**	□ **Head Injury**
□ **Diabetes Mellitus**	□ **Pneumonia**	□ **Back Injury**
□ **Hypothyroidism**	□ **Obstructive Sleep Apnea**	□ **Migraine Headaches**
□ **Hyperthyroidism**	□ **Emphysema**	□ **Sexually Transmitted Diseases/Infections**
□ **Hepatitis A B or C**	□ **Tuberculosis**	□ **Prostate Problems**
□ **Anemia**	□ **Food Allergies**	□ **Urinary Incontinence**
□ **Gastric/Peptic Ulcer(s)**	□ **Seasonal Allergies**	□ **Cancer (Type)_____**
□ **Blood Transfusion**	□ **Covid-19 Infection**	□ **Other:**

Past Surgical History:	**Family Medical History:**		Medical History	Cause of Death if Applicable
□ **Hernia** □ **Ulcer Repair** □ **Hysterectomy** □ **Oophorectomy** □ **Mastectomy** □ **Prostate** □ **Spine Surgery** □ **Cancer** □ **Other:**	**Father:**	□ Living □ Deceased	□ High Blood Pressure □ Heart Disease □ Stroke/TIA □ High Cholesterol □ Diabetes □ Anemia □ Cancer □Tuberculosis	
	Mother:	□ Living □ Deceased	□ High Blood Pressure □ Heart Disease □ Stroke/TIA □ High Cholesterol □ Diabetes □ Anemia □ Cancer □Tuberculosis	
	Sibling(s):	□ Living □ Deceased	□ High Blood Pressure □ Heart Disease □ Stroke/TIA □ High Cholesterol □ Diabetes □ Anemia □ Cancer □Tuberculosis	
	Children:	□ Living □ Deceased	□ High Blood Pressure □ Heart Disease □ Stroke/TIA □ High Cholesterol □ Diabetes □ Anemia □ Cancer □Tuberculosis	

PLEASE COMPLETE REVISED SIDE →

Current Medications:	**Allergies/Reaction:**

Social History:

Tobacco Use:	Alcohol Use:	Drug Use:	Caffeine Use:
☐ Never ☐ Quit/When_____ ☐ Cigarettes/Pack per Day? _____ ☐ Pipe ☐ Cigars ☐ Chewing Tobacco ☐ For how long? _____	☐ Never ☐ Socially ☐ Daily ☐ Heavy consumption Have you ever been treated for alcoholism? ☐ Yes ☐ No If yes, when? _____	☐ Never ☐ Marijuana ☐ Amphetamines ☐ Other: _____ Have you ever been treated for drug use? ☐ Yes ☐ No If yes, when? _____	☐ Never ☐ Daily ☐ Occasional Seatbelt Use: ☐ Yes ☐ No Exercise: ☐ Yes, Often ☐ Sometimes ☐ No

PLEASE CHECK ALL THAT APPLY

General	**Gastrointestinal**	**Skin and Joints**
☐ Significant weight gain	☐ Change in appetite	☐ Unusual pain in joints
☐ Abnormal bruising or bleeding	☐ Difficulty swallowing	☐ Swelling or stiffness
☐ Fever	☐ Heartburn	☐ Pain/weakness in joints
Head and Nerves	☐ Excess gas	☐ Skin sores or rash
☐ Depression/Anxiety	☐ Nausea	☐ Leg pain when walking
☐ Difficulty sleeping	☐ Vomiting	☐ Muscle cramps
☐ Memory loss	☐ Vomiting with blood	**Heart and Respiratory**
☐ Headaches	☐ Diarrhea	☐ Shortness of breath
☐ Dizziness or fainting	☐ Constipation	☐ Shortness of breath while laying down
☐ Eye Disease or injury	☐ Hemorrhoids	☐ Asthma
☐ Use glasses or contacts	☐ Blood in stools or black stools	☐ Cough or wheezing
☐ Hearing loss	**Urinary**	☐ Cough with blood
☐ Ringing in ears	☐ Frequent urination	☐ Chest pain
☐ Nose bleeds	☐ Frequent urination at night	☐ Heart palpitations
☐ Sore gums	☐ Painful urination	**Gynecology**
☐ Numbness/Tingling in hands or feet	☐ Urinary hesitancy	Age of First Menstrual Period:
Breast	☐ Cloudy or foul-smelling urine	First day of Last Period:
☐ Lumps	☐ Blood in the urine	Usual Length of Period:
☐ Discharge	☐ Loss of urine control	Painful Menses?
☐ Breast Tenderness/Pain	☐ Pelvic/Lower back pain	Number of Pregnancies:
☐ Redness	☐ Sexually Active	Number of Miscarriages:
☐ Itchiness/Rash	☐ Safe sex activity	Number of Children Alive:

PRIMARY HEALTH CARE MEDICAL GROUP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Authorization: I authorize the disclosure of medical information and health records as described below:

Name of Patient: _____ DOB: ____/____/_____

Record Holder: _____

Telephone:_____

FAX: _____

Records May Be Release To: **Primary Healthcare Medical Group**
Lorenzo H. Suarez, M.D., A.A.F.P.
Family Practice
125 S. 5th Street
Brawley, CA 92227
Main Office Telephone #: (760) 344-8100
Electronic FAX#: (866) 493-3117

Type of Information: This authorization applies to the following types of information marked besides each applicable category

_____ Psychiatric Records _____ Treatment for alcohol and/or drug abuse HIV Test Results (Human Immunodeficiency Virus

✓ Discharge Summary	✓ Progress Notes
✓ History/Physical Exam	✓ Laboratory
✓ Consultation Reports	✓ Diagnostic Imaging Reports
✓ Operative/Procedure	✓ Emergency Department Records

Other (please specify): _____

Dates Requesting: From ____/____/_____ To ____/____/_____

Duration: This authorization is valid one year from the date next to my signature unless otherwise specific

SIGNATURE: _____ **DATE**: _____

CIRCLE IF STAT

PRIMARY HEALTH CARE MEDICAL GROUP

PATIENT FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

Co-pays
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due and payable at the time of service.

Self-Pay Accounts
Self-Pay accounts are patients who are covered by insurance plans that the clinic does not participate in, patients without an insurance card on file, or at the time of service, do not meet the deductible. It is expected that payment is required at the time of service for all services including surgeries.

Extended Payment Arrangements
For procedures exceeding $300, 75% of the total fee from an office visit is to be paid at the time of service or 75% of the total fee for a surgical procedure is to be paid prior to the procedure. The remaining balance is to be paid over the next three months in equal monthly payments due to the first of every month.

Non-Participating Insurance Plans
The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a Self-Pay account. The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient paying the clinic the amount in full. The insurance company will reimburse the patient on non-assigned claims. If the clinic receives payment for a non-assigned claim, the patient will receive a refund within 10 days.

Automobile Accident Cases
The patient will be treated as a Self-Pay account unless a subrogation agreement is provided by health insurance. If subrogation agreement is provided and the physician participates with the insurance carrier, the health insurance is billed. If an attorney is involved in the case, a letter of protection will be obtained whether an insurance carrier is involved or not.

Patient Refunds
The following criteria must be met prior to issuing a patient refund: The patient has not been seen in the office for 90 days, there are no outstanding insurance claims on the patient's account and there are no outstanding patient balances on the account.

Divorce Cases
In cases of divorce, the individual who receives the care is responsible for payment of copays, coinsurance and non-participating insurance balances at the time of service. We will not bill no bill a divorced spouse for the patient's service.

Child Custody Cases
The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay participating insurance or non-participating insurance. If the non-custodial parent carries the insurance on the child, the clinic will bill that insurance company. The clinic does not get involved with divorces specifics, e.g., one parent pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement themselves or through the court system.

Referrals
If your insurance has designated a Primary Care Physician (PCP), you are required to have prior authorization from your PCP prior to your clinic visit. If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at time of service.

This financial policy helps the clinic provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to ask the receptionist.

_____ _____
Patient/Guardian Signature: Date:

_____ _____
Witness Signature: Date: