Richmond District Medical Group, Inc.

NEW PATIENT CHECKLIST

1. Please provide our front office with your health insurance card and ID card (if applicable)

2. Please complete the following forms:

   - ❑ **Page 1 -** Patient Registration
   - ❑ **Page 2 -** Medical Information
   - ❑ **Page 3 -** Notice of Privacy Practices Written Acknowledgment Form
   - ❑ **Page 4 -** Office Policies (may change without notice)
   - ❑ **Page 5 -** Authorization for Disclosure of Protected Health Information. This authorizes release of medical records from your previous health care provider. If this is not required for you then you do not need to complete the form.

3. Please Keep a Notice of Privacy Practices (last page) for your records

4. Please return your completed forms to the receptionist at the front desk

Please make sure to complete <u>all</u> areas. Copies available upon request.

RICHMOND DISTRICT MEDICAL GROUP,INC.

PATIENT REGISTRATION

PATIENT INFORMATION: Date_____

Name (First, Middle, Last) _____ SSN _____

Address_____ Primary Tel # _____ ☐ CELL ☐ HOME

City _____ State _____ Zip Code _____ Sec Tel# _____ ☐ CELL ☐ HOME

Date of Birth _____ Age _____ Language _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ Caucasian ☐ Other ☐ Declined

STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Partner/Significant Other ☐ Separated ☐ Widowed ☐ Minor

Employed by _____ Occupation _____

Work Address _____ Work Tel# _____

City _____ State: _____ Zip Code: _____

SPOUSE:

Name (First, Middle, Last) _____ Tel # _____

Employed by _____ Occupation _____

Work Address _____ Work Tel# _____

City:_____ State:_____ Zip Code: _____

LOCAL CONTACT FOR EMERGENCY: _____ Tel #_____

Address _____ Relation _____

City _____ State _____ Zip Code _____

PHARMACY: _____ Tel # _____

REFERRED BY: _____

RESPONSIBLE PARTY FOR PAYMENT:

☐ SELF

☐ OTHER

Name (First, Middle, Last) _____ Date of Birth _____

Home Address _____ SSN _____

City _____ State _____ Zip Code _____ Tel# _____

Employed by _____ Occupation _____

City _____ State _____ Zip Code _____ Work Tel# _____

INSURANCE:

☐ SELF-PAY/NO INSURANCE

☐ Primary Insurance _____ Type: ☐ HMO ☐ PPO ☐ EPO Subscriber: ☐ Self ☐ Spouse ☐ Other

Member/Subscriber ID# _____ Group# _____

☐ Secondary Insurance _____ Type: ☐ HMO ☐ PPO ☐ EPO Subscriber: ☐ Self ☐ Spouse ☐ Other

Member/Subscriber ID# _____ Group # _____

Primary Care Physician _____

Patient or authorized person's signature: I authorize the release of any medical information or other information necessary to process this claim. I also request of government benefits either to myself or to the party who accepts assignment below.

SIGNATURE_____ **Date** _____

RICHMOND DISTRICT MEDICAL GROUP,INC.

MEDICAL INFORMATION

Name _____ **Date of Birth** _____ **Today's Date** _____

Major Medical Problems: _____

What medications are you currently taking? (Include over-the-counter medication)

_____ _____ _____

_____ _____ _____

Past surgeries with approximate year done:

_____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery with approximate date:

_____ _____ _____

_____ _____ _____

Vaccination History: (Place an "x" in the boxes below):

Pneumonia Vaccine ☐ NO ☐ YES ☐ DON'T KNOW Date when last given _____

Tetanus Vaccine ☐ NO ☐ YES ☐ DON'T KNOW Date when last given _____

Other _____ Date when last given _____

Family History: Has any member of your family (including parents, brothers/sisters) ever had the following?

Illness	Which parent, brother, or sister?	Illness	Which parent,brother,or sister?
Cancer (describe type)	_____	Mental Illness	_____
High Blood Pressure	_____	Alcohol/Drug Abuse	_____
Heart Disease	_____	High Cholesterol	_____
Diabetes Mellitus	_____	Other	_____

FOR WOMEN: Gynecologic and Obstetric History:

# of Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

History of any abnormal pap smears?..... ☐ NO ☐ YES...When and what happened afterwards?_____

When was your last pap smear? _____ What, if any, birth control method did you use? _____

Other Information: (Place an "x" in the boxes below):

Do you smoke? …… ☐ NO ☐ YES.....If yes, how many packs per day? _____ How many years?_____

Are you a former smoker?..... ☐ NO ☐ YES..... If you quit in the past what did you try? _____

How long did you quit? _____

Do you drink alcohol? …… ☐ NO ☐ YES....How much per week? _____ What type? _____

Have you used illegal drugs?..... ☐ NO ☐ YES.....What type? _____When did you last use? _____

Caffeine use?..... ☐ NO ☐ YES....How much? _____

Do you exercise?..... ☐ NO ☐ YES.....What type? _____ How often per week? _____

History of sexually transmitted diseases?..... ☐ NO ☐ YES....What type? _____ When? _____

Allergies to medications, x-rays, dyes, or other substances: ☐ NO ☐ YES....If yes, please list substance & reaction below: Medication/Substance: Reaction: Medication/Substance: Reaction:

_____ _____ _____ _____

_____ _____ _____ _____

This information is for use by your physician as part of your confidential medical record.

RICHMOND DISTRICT MEDICAL GROUP, INC.
700 25th Avenue
San Francisco, CA 94121
Phone: 415-751-1446 Fax: 415-752-6312
■ Mei-Lai Lucas, M.D. ■ Joshua Rassen, M.D. ■ May Deng, PA-C ■ Karlee Johnson, PA-C

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM:
EFFECTIVE DATE OF THIS NOTICE: APRIL 14, 2003

I, _____, have received a copy of the Notice of Privacy Practices.
Patient Name

_____ _____
Patient Signature Date

***For office staff only**: In lieu of patient signature, I, _____, a staff*
(Staff Member Name)

member of this office, state that _____ has been given our Notice of
(Patient Name)

Privacy Practices.

_____ _____
(Staff Member Signature) *Date*

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

☐ Home Telephone #_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work address

☐ Mobile Telephone #_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back number only

☐ Fax #_____
- ☐ OK to fax

☐ Work Telephone #_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with callback number only

☐ Other _____
_____

_____ _____
Patient Signature Date

RICHMOND DISTRICT MEDICAL GROUP, INC.

OFFICE POLICIES EFFECTIVE JUNE 20, 2019

Welcome! We are pleased that you are joining our medical practice and we want to let you know that we are committed to providing you the best medical care. We also want to help you receive your maximum allowable benefits if you have health insurance. In order to do so we need your partnership and clear understanding of our financial policies. Therefore, we ask that you read and understand the following:

YOUR INSURANCE — It is the responsibility of the patient to know what your plan will cover. If you are unable to show proof of insurance then you must pay in full at the time of the office visit.

MISSED APPOINTMENTS — Appointments that are not kept or cancelled without enough notice unfairly deprive other patients of an appointment and are costly to our practice. Therefore we charge a fee of $75 for *new patients* and $35 for *returning patients* if you fail to inform us of an appointment cancellation with less than 24 hours notice.

SELF-PAY PATIENTS — Payment is due at the time of the visit. We charge $75 for a routine office visit at $150 for a physical exam.

CREDIT CARDS — We accept credit card payments including VISA, MasterCard and American Express.

CO-PAYMENTS — Co-payments MUST be paid at the time of the office visit PRIOR to seeing the provider. Co-payments are collected for all office visits including staff treatments such as blood pressure checks.

COPY OF RECORDS — We must receive signed consent to authorize copying and releasing of a patient's medical records. We charge a base fee of $25 for two years or less of patient records. For more than 2 years we charge the base fee and an additional 0.25 cents per page. You may also request that a copy service make copies of the chart. Forms are available at the front desk.

FORMS AND LETTERS — We must charge a fee for to complete forms and to draft letters since these activities are very time consuming. This is a common charge for most medical offices. We charge $15 to complete forms that are 2 pages or less and $25 if forms are more than 2 pages. We charge $25 to draft a medical letter and sick notes without an office visit. Payment must be received before the form is released or mailed.

DISABILITY FORMS — It is lawful for providers to charge for completion of disability and EDD forms since they are very time consuming. We charge $25 for completion of these forms.

WORKER'S COMP — We do not accept or handle Worker's Comp

STAMPED ENVELOPES — Due to rising postal and printing costs we must charge for all mailing requests. This includes requests for forms, letters or prescriptions that require a stamped envelope. We charge a $3 fee for postage and handling if we do not receive a fully prepared envelope.

LABCORP & QUEST LABS — Labcorp & Quest labs do pick ups of lab specimens that are drawn at our office. We provide this service as a courtesy for our patients. However, if your insurance is NOT contracted with either of these labs then you will be billed for their services. It is YOUR responsibility to know which lab is affiliated with your insurance *before* getting your blood drawn.

PRESCRIPTION REFILLS — Please have your pharmacist contact us directly by fax or electronic prescription if you need a refill. Allow 24-48 hours for refill requests.

TRAVEL VACCINES — Most insurances don't cover travel vaccines. Please confirm coverage with your insurance.

JURY DUTY EXCUSE — We charge a $25 fee for writing a jury duty excuse letter. Please let us know the medical reason that prevents you from serving. Patients 70 years of age or older do not require a letter.

I have read and agree to the terms outlined above for the Richmond District Medical Group Office Policies.

Please Print Name	Patient Signature	Date

RICHMOND DISTRICT MEDICAL GROUP, INC.
700 25th Avenue
San Francisco, CA 94121
Phone: 415-751-1446 Fax: 415-752-6312
■ Mei-Lai Lucas, M.D. ■ Joshua Rassen, M.D. ■ May Deng, PA-C ■ Karlee Johnson, PA-C

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM
I authorize use/disclosure of health information about me as described below:

Patient Name _____ Date of Birth _____ (mm/dd/yyyy)

1. Person(s) or Organization(s) authorized to **provide** the information:
   Name of office/hospital/facility to provide records: _____
   Address: _____
   Telephone #: _____
   Fax #: _____

2. Person(s) or Organization(s) authorized to **receive** the information:
   RICHMOND DISTRICT MEDICAL GROUP
   700 25TH AVENUE
   SAN FRANCISCO, CA 94121
   TELEPHONE# 415-751-1446
   FAX# 415-752-6312

3. Specific description of the information that may be used or disclosed (date of service and type of service):

   ☐ All health information including HIV test if part of the record
   ☐ Other (explain) _____
   _____

4. Specific description of how the information will be used:

   ☐ Continuity of care
   ☐ At the request of the individual
   ☐ Insurance application
   ☐ Disability application
   ☐ Other

(explain)_____
_____

I. I understand that this authorization will expire in six months unless another date is specified _____ (date: mm/dd/yyyy).
II. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying this office in writing.
III. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
IV. I may inspect or copy any information used or disclosed under this agreement (There may be a copying fee).
V. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.
VI. I understand that this office may receive compensation from a third party for the use or disclosure of my information or that I may be billed a nominal fee for providing such.
VII. You have the right to receive a copy of this form.

_____ _____
Patient Signature (or Signature of Patient's Representative) Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Richmond District Medical Group, Inc.
Notice of Privacy Practices
Effective April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THIS OFFICE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

The terms of this Notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice. Any revision or amendment to this Notice will be effective for all of your records that our practice has created or maintained in the past, and for any or your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your health information. By federal and state law, we must follow the terms of the Notice that we have in effect at that time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose the health information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing our practice's privacy officer.

•**Treatment:** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

•**Payment:** We may use and disclose Health Information so that we, or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

•**Health Care Operations:** We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the primary care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

•**Appointment Reminders, Treatment Alternatives and health Related Benefits and Services:** We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

•**Individuals Involved in Your Care and/or Payment for Your Care:** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as you family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

•**To Help Us Educate Medical Staff and Students:** Our practice has associations with a variety of schools involved in the education of health professionals. All staff and students must sign a confidentiality agreement before accessing any Health Information maintained by our practice.

•**Research:** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

•**As Required by Law:** We will disclose Health Information when required to do so by international, federal, state or local law.

•**To Avert a Serious Health Threat or Safety:** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

•**Business Associates:** There are some services provided to our practice through contracts with business associates. When these services are provided, we may disclose the appropriate portions of your Health Information to our business associates so they can perform the job we have asked them to do. To protect your health information, however, we require all business associates to sign a confidentiality agreement verifying they will appropriately safeguard your information.

•**Organ and Tissue Donation:** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement.

•**Military and Veterans:** If you are a member of the armed forces, we may release Health Information as required by the military command authorities. We may also release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

•**Worker's Compensation:** We may disclose Health Information to the extent authorized by and necessary to comply with the laws relating to worker's compensation or other similar programs established by law.

•**Public Health Risks:** We may disclose Health Information as required by law to public health, legal authorities, or other healthcare agencies/registries charged with preventing or controlling disease, injury or disability.

•**Health Oversight Activities:** We may disclose health Information to a health oversight agency for activities authorized by law.

•**Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may disclose Health Information in response to a court or administrative order. We may also disclose Health Information in response to subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested..

•**Law Enforcement:** We may disclose your Health Information for law enforcement purposes as required by law or in response to a valid subpoena, or court or administrative order.

•**Coroners, Medical Examiners, and Funeral Directors:** We may release Health Information to a coroners, medical examiners or funeral director as necessary for their duties.

•**National Security and Intelligence Activities:** We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

•**Protective Services for the President and Others:** We may disclose Health Information federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

•**Inmate or Individuals in Custody:** Should you be an inmate of a correctional institution, we may disclose to the institution or their agents Health Information necessary for your health and the health and safety of other individuals.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

•**Obtain a copy of this Notice:** You will receive a copy of this Notice at your first visit or after its publication. Thereafter, you may request a copy of this Notice by calling (415) 751-1446.

•**Authorized to Use Your Health Information:** Before we use or disclose your Health Information, other than described above, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

•**Access to Your Health Information:** You may request a copy of your Health Information. Your request must be submitted in writing. We may charge for the costs of providing you access and for your copies.

•**Amend Your Health Information:** If you believe the information we have about you is incorrect or incomplete, you may request or add information. Your request must be submitted in writing and you may pick up a form for this purpose from a staff member.

•**Request Confidential Communication:** You may request that, when we communicate with you about your Health Information, we do so in a specific way (e.g. at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

•**Limit Our Use or Disclosure of Your Health Information:** You may request in writing that we restrict the use or disclosure of your Health Information for treatment, payment, health care operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services.

•**Accounting of Disclosure:** You may request a list of disclosures of your Health Information that we have made for reasons other than treatment, payment or healthcare operations. Disclosures that we make with your authorization will not be listed.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information, you may call our privacy officer at (415) 751-1446. If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact our privacy officer at (415) 751-1446. You may also send a written complaint to:

United States Department of Health & Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Room 509, Washington, D.C. 20201

This office will ensure that the care you receive at our practice will in no way be impacted if you file a complaint.