MGNC Medical Group of North County, Inc.

910 Sycamore Ave., Suite 270 Vista, CA 92081 Phone: 760-598-1776

Internal Medicine: Mary Jaramillo, MD, Neil Levine, MD, MPH, FACP, Charles Hergesheimer, MD, Karen Cadman, MD, Sam Baroudi, MD, Loren Novak, DO, Ann Bouck, F-NP

Patient Name ____ Female Male **Age** _________

Address ____ **Home Phone** ________________

City _______________________________ **Zip** ___________ **Other Phone/Cell** ______________

SSN ________-_______-________**Birth Date** ____/____/____ Single Married Widowed

May we give any medical information/results to your spouse? Yes No

May we leave lab/x-ray results on your answering machine? Yes No

May we email you with medical information? Yes No

Occupation __________________________________ May we contact you at work? Yes No

Employer ____ **Phone #** _______________________

Address ____

Referred By ________________________________ Family M.D. __________________________

Name of Spouse or Parent ____

Spouse/Parent's SSN _______-______-________ Spouse/Parent's Birth Date ________________

Spouse's Occupation ____________________________May we contact him/her at work? Yes No

Spouse's Employer ____ Phone #____________________

Address ____

Person not living in your household to contact in case of an emergency:

Name ____

Relationship to patient ____

Address ____ Home Phone ________________

City ______________________________ Zip ________________ Work Phone _________________

Primary Insurance

Name____

Policyholder/Sponsor Name ____________________________________ Birth Date _______________

Policy ID# _________________________ Group Name and/or Military Branch# _________________

Secondary Insurance Name ____

Policyholder/Sponsor Name ____________________________________ Birth Date _______________

Policy ID# _________________________ Group Name and/or Military Branch# _________________

To Our Patients:
Fees for services rendered are payable at the time of service unless previous arrangements have been made, or hospitalization is required. We accept assignment for Medicare and most insurance plans. I hereby authorize medical and billing information to be released to my insurance company.

Patient Signature ____ Date _____________________

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CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE
(Please Complete Both Sides)

Name ______________________ Date of Birth ________ Age _____ Today's Date _______

SURGERIES (include skin, eye, orthopedic, etc):

Type of Surgery	Month/Year	Type of Surgery	Month/Year
1.		4.	
2.		5.	
3.		6.	

MEDICAL HISTORY (i.e.: ulcers, stroke, high blood pressure, arthritis, thyroid, cholesterol, etc.):

Please list the medical problem(s) that prompted you to see the doctor.

Type of Problem	Approx. Date of Onset	Type of Problem	Approx. Date of Onset
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Last Menstrual Period: ____________________ Number of Pregnancies: __________ G P A L

Colonoscopy (date): ____________________ Last Mamogram Date: ____________________

Date of Last Flu Vac:______ Pnuemo Vac.: ______ Last Pap Test Date: ____________________

CURRENT MEDICATIONS (include over-the-counter medications):

Name	Dose (milligrams)	How Often/Day	Name	Dose (milligrams)	How Often/Day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

DRUG ALLERGIES:

Name of Drug	Type of Reaction (i.e. rash, hives, shortness of breath, upset stomach, etc.)

HABITS:

Please list any special dietary restrictions or diet followed: ______________________________

How many cups of coffee or other caffeinated beverages do you drink per day? ____________________

Do you use tobacco? ________ Did you use tobacco in the past? ________ What year did you quit? ________

How many packs per day? ________ How many total years have you used? ______________

Do you drink alcohol? __________ How much per day? ____________ Type? ________________

Have you ever used intravenous drugs? (this information will remain confidential) ________________

Please check one: ☐ Heterosexual ☐ Bisexual ☐ Homosexual

Calcium Intake: Supplements/Dairy Products (amount, type, frequency) ______________________

Exercise: Type ____________________ Duration ______________ Frequency______________

FAMILY HISTORY (Cancer, Diabetes, Dementia, Coronary Disease, Osteoperosis, Other):

	Deceased or Living	Age (current or at death)	Diagnosis or Cause of Death
Father	________	________	________
Mother	________	________	________
Brothers	________	________	________
Sisters	________	________	________
# of Sons	________	________	________
# of Daughters	________	________	________

Other illnesses in family: ________________________________

SOCIAL HISTORY: ________________________________

Occupation: ____________________ Are you retired? ____________

Marital Status: ____________________ How Long? ____________

Hobbies: ________________________________

Toxic Chemical Exposures ________________________________

MEDICAL ILLNESSES AND SYMPTOM REVIEW:

Please check the box if you have had any of the following illnesses or symptoms.

1. ☐ Recent fever
2. ☐ Recent weight change
3. ☐ Excess fatigue or weakness
4. ☐ Diabetes
5. ☐ Thyroid or other hormonal problem
6. ☐ Any type of cancer
7. ☐ Anemia or other blood disorder
8. ☐ Previous blood transfusion
9. ☐ Skin rash or unusual mole
10. ☐ Glaucoma or other eye problem
11. ☐ Recent ear, nose, throat problem
12. ☐ Hay fever or sinusitis
13. ☐ Exposed to excess dust, toxic chemicals or fumes
14. ☐ Chronic lung disease or asthma
15. ☐ New or chronic cough
16. ☐ Unusual shortness of breath with moderate activity or exercise
17. ☐ Shortness of breath caused by lying flat
18. ☐ Swelling in feet or ankles
19. ☐ High blood pressure
20. ☐ High cholesterol/triglycerides
21. ☐ Any type of heart disease
22. ☐ Previous heart attack
23. ☐ Previous heart murmur
24. ☐ Recurrent chest pain/discomfort
25. ☐ Palpitation or irregular pulse
26. ☐ Leg cramps when walking
27. ☐ Blood clot in leg or lung
28. ☐ Recent abdominal pain
29. ☐ Recent nausea or vomiting
30. ☐ Change in bowel movements
31. ☐ Recent blood in stools/black stools
32. ☐ Heartburn or hiatal hernia
33. ☐ Stomach or duodenal ulcer
34. ☐ Spastic colon, diverticulosis, or recurrent colitis
35. ☐ Polyp or tumor of the colon
36. ☐ Hepatitis or liver disease
37. ☐ Any problem with urine flow, frequency or unusual color
38. ☐ Kidney stones
39. ☐ Infection of kidney or bladder
40. ☐ Sexually transmitted disease
41. ☐ Serious sexual dysfunction
42. ☐ Previous prostate problem
43. ☐ Recent menstrual problem
44. ☐ Any breast problems
45. ☐ Arthritis or painful joints
46. ☐ Chronic or new back pain
47. ☐ Difficulty walking
48. ☐ Recent dizziness
49. ☐ Passing out or fainting spells
50. ☐ Previous stroke
51. ☐ Seizures or tremor
52. ☐ Headaches
53. ☐ Feelings of depression
54. ☐ Excess stress or anxiety
55. ☐ Insomnia

MGNC Medical Group of North County, Inc.

STATEMENT OF FINANCIAL POLICY

The Medical Group of North County, Inc. is a provider for many insurance plans and will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. However, to avoid any confusion, be aware that we do expect payment of any applicable deductible, co-payments or co-insurance amounts at the time of service. Also, any services that your insurance will not cover are your responsibility.

If your insurance requires prior authorization for any of your treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred. If your insurance subsequently authorizes today's services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will still bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays within 30 days.

If you do not have insurance, payment is expected at the time of service. We accept Visa and Mastercard for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms, (such as for disability, Department of Motor Vehicles, Assisted Living Admission Forms or other physician report forms), there will be a **$75.00 fee per form**.

Statements are mailed monthly to patients with an outstanding balance. We may assess interest @ the rate of 1% per month on all accounts over 60 days. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 598-1700 to make payment arrangements, unless a payment schedule already exists.

If you must cancel your appointment, please give us at least 24-hours' notice so we can schedule another person in your place. There is a **Missed Appointment Fee of $40.00** charged for appointments not cancelled with 24-hours notice. This fee will be waived if a phone call is received within the specified timeframe or if documentation of an emergency can be provided.

Billing Office hours are 8:30 A.M. to 4:30 P.M., Monday through Friday. If you reach our voicemail, please leave a detailed message and we will return your call as soon as possible.

Thank you for choosing Medical Group of North County, Inc.

I have read and understand the Medical Group of North County, Inc, financial and claims filing policies.

PRINT PATIENT NAME ____

Patient Signature ____ Date _____________

Responsible Party Signature ______________________________________ Date _____________

MGNC Medical Group of North County, Inc.

We are committed to providing you with the very best of health care. Please read this form and sign at the bottom.

Financial Policy
Payment for services is due at the time of service. We accept cash, checks, MasterCard and Visa. We will be gladly to file your insurance claims if you are a member of a plan with which we are contracted.

Please remember:

- Your insurance is a contract between you, your employer and the insurance company.
- Not all services are a benefit of your contract.
- Non-covered services are your responsibility.
- There may be an invoicing charge of $25.00 if your co-pay or other fees are not paid at the time of service.

Medical Records
Medical Records are the property of Medical Group of North County. You have the right to review your records or request a copy of it. The charge to copy your record for personal use (to be paid in advance) or for a new primary care physician is $25.00 (California Code 1560-1567).

Medical Correspondence
Written correspondence for various purposes is available for fee.

Form fees:

- DMV forms (excluding Handicap placard forms) $75.00
- Disability forms $75.00
- School physical form $75.00
- Assisted Living admission form $75.00
- Other detailed forms $75.00

Cancellations and Missed Appointments
24 hour notice is required for cancellations. Missed appointments or less than 24 hour notice will be assessed. The following charges are to partially recover our staffing costs and reserved physician's time.

New Patient Missed Appointment $100.00
Follow-Up Missed Appointments $40.00

I have read and understand the above statements and agree to abide by these policies.

____
Signature Date

MGNC Medical Group of North County, Inc.

Notice of Privacy Practices Acknowledgement

Under the Health Insurance Portability and accountability Act (HIPAA) of 1996 you the patient have certain rights to privacy regarding your protected health information (PHI). This information can be disclosed to other entities for the purposes of:

1. **Treatment:** The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consulting between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
2. **Payment:** Reimbursement for the provision of healthcare, which includes but is not limited to: Billings, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.
3. **Health care operations:** Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, (provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities); population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

I have received, read and understand MGNC/SDCC's full and complete version of its *Notice of Privacy Practices.* I understand that I may request: restrictions on disclosures, a history of non-routine disclosures, access to your medical records and that my protected health information be amended. However, MGNC/SDCC does not have to agree to the requested restriction but if we do we are bound to abide by them. In addition, MGNC/SDCC does not have to grant access to or amend your medical record if it is not in your best interest as determined by your physician.

Patient Name____________________________ Relationship to Patient____________________________

Signature_______________________________ Date_____________________

OFFICE USE ONLY

I attempted to secure the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so.

Reason for not signing____

Date:___________________ Initials____________________________

MGNC Medical Group of North County, Inc.

AUTHORIZED INDIVIDUALS FORM

Please list all individuals that are authorized to receive your medical information either verbal or written.

NAME	Phone	Relationship
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________
______________________________	_____________________	________________________

____

Signature of Patient   Print Name

____

Date

MGNC Medical Group of North County, Inc.

<u>OFFICE POLICY</u>

Welcome to Medical Group of North County. We are pleased you have chosen us as your primary care physicians. Please read the following office policies to help insure all aspects of your medical care is handled effectively and with out unnecessary delay.
To familiarize yourself with our office please visit our **Web site: www.mgnc.net**

OFFICE HOURS

The office is open to patients from 8:15 a.m. to 5:00 p.m., Monday through Friday, except for major holidays. Our ***LAB*** is open 8:30 to 4:30 Mondays through Thursday. Fridays 9:30 to 4:30. We are not open weekends.

CALLS DURING OFFICE HOURS

We can often meet your needs with advice or instructions over the phone. Each of our physicians has their own medical assistant and voicemail system. To save time, travel and the cost of an office visit, we encourage you to call the office and ask to speak with your physician's assistant. ***If she is not available to take your call*** then our receptionist will offer you her voicemail. The voicemail messages are retrieved several times during the day and will be answered in order of urgency. If you feel this is an emergency or if you need to schedule an appointment please inform the receptionist and she will help you. Non-urgent calls will be returned within 24 hours.
DO NOT LEAVE EMERGENCY MESSAGES ON THE VOICE MAIL SYSTEM.

SCHEDULING APPOINTMENTS

WE SEE PATIENTS BY APPOINTMENT ONLY. If you are ill and wish to be seen, call ahead for an appointment, this will minimize your waiting time. We will always try to accommodate your appointment to your medical needs and schedule. If you need to be *seen on the same day* as your call and if your usual physician is not available to see you, then you will be offered an appointment with one of the other physicians in our office who have available time in their schedule, or with our Nurse Practitioner.

COPAYS

Insurance co-pays are due payable at the time of your visit. We accept cash, check or Master Card. There is a $25.00 administrative charge if we bill you for unpaid co-pays.

PRESCRIPTIONS AND REFILLS WE REQUIRE 48 HOURS FOR REFILLS

If you need a new prescription called to a local pharmacy please leave this request on the voicemail system. Please provide us with the pharmacy name and phone number, the medication name, milligram and how many times you take this medication daily. If you are requesting a written Rx to mail away, most mail away RX's are for 90 day supplies. We will send the written RX to your home. We do not fax prescriptions to mail service pharmacies. Some types of medications require that written prescriptions be picked up at our front desk. Medications requiring *prior authorizations* frequently take up to 7 days to be processed by your insurance company.
REFILLS. Most of the pharmacies in the area are aware how to obtain prescription refills. If the pharmacy states that they have called us and that they are waiting on a call back for an approval from our office, please ask them to refax the request if it has been more than 48 hours. **NO NARCOTICS OR SEDATIVES** are prescribed or refilled after hours or on weekends.

LAB RESULTS Due to the high volume of daily labs we review, we will not be notifying you of "normal" lab results. You will certainly be informed of anything "abnormal" either by mail or phone depending on the test result. If you must have a copy of your labs please provide our office with a self addressed, stamped envelope and we will mail a copy to you.

CALLS AFTER HOURS OR WEEKENDS

We have a physician on call at all times when the office is closed. We request that you reach this physician BEFORE seeking medical attention for a NON- LIFE THREATING EMERGENCY. To reach the on call doctor, which is usually one of our physicians, dial our regular office number (760) 598-1776, a recorded message will instruct you to press "0" or stay on the line and a phone operator will answer your call. She will contact the physician on-call and you will receive a call back. Please have the following I information available.

1. A brief description of your symptoms
2. Any chronic illness that you have.
3. Your current medications
4. Any allergies to medications
5. The name and phone number of your pharmacy.

If you have a HMO insurance plan then the above information is very important, as you are required by your plan to get verbal authorization from a physician BEFORE you seek medical attention for a NON-LIFE THREATING event. If this is not done prior to your treatment by an outside facility, then you may be responsible for the bill.

If you are out of town (more than 25 miles from home) and need medical attention, then call the emergency phone number on the back of your insurance card, they will instruct you where to go for help; do not call your physician.

MISSED APPOINTMENTS

Please call the office 24 hours in advance if your are unable to keep your appointment, as we appreciate the opportunity to offer your visit time to another patient. We will make every effort to contact you two days prior to your appointment to remind you of your visit but it is your responsibility to reschedule if conflicts arise. If you arrive more than 15 minutes late for your scheduled appointment time, you most likely will have to wait to be seen until the schedule permits you time with the doctor or nurse practitioner or may be necessary to reschedule. There may be a $40.00 charge for appointments not cancelled 24 hours prior. If you miss more then 3 scheduled appointments without notifying the office ahead of time that you will not be keeping your appoint, then you may be asked to find a new physician.

REFERRALS

In most cases, you will need to see your doctor or the nurse practitioner in order to get a referral initiated. From that point, please allow 7 to14 days for the referral to be processed. You should receive notification in the mail that your request has been approved. If after 14 days you have not received written notice then contact your physician's assistant through the voice mail system.

Specialist offices are responsible for obtaining any referrals for additional tests or follow up appointments.