Vista Del Mar Medical Group, Inc.

Health Questionnaire

OXNARD OFFICE
1200 West Gonzales Road
Suites 100 & 300
Oxnard, CA 93036
(805)983-0691

VENTURA OFFICE
4567 Telephone Road
Suite 102
Ventura, CA 93003
(805)644-6673

CAMARILLO OFFICE
2412 Ponderosa Drive North
Suite B-100
Camarillo, CA 93010
(805)482-5699

SANTA PAULA OFFICE
242 East Harvard Blvd.
Santa Paula, CA 93060
(805)983-0691

In order to best serve your medical needs, we ask that you fill out the following questionnaire as completely as possible. The health care provider- health care consumer relationship is a privileged relationship built on trust and honesty. By completing and signing this form you understand that any intentionally false information may adversely affect your health.

Name ________________________ **D.O.B.** ____/____/____ **Gender:** ☐**Male** ☐**Female**

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/ Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unknown
- ☐ Decline to State

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to State

Marital Status: ________________ Occupation: ________________________

Do you have a personal history of the following/ Circle those that apply and explain if necessary.

Hypertension Diabetes
Tuberculosis Asthma
Pneumonia Heart Disease
Heart Attack Stroke

Explanation: ________________________
____
____
____

Have you had any surgeries in the past? List type and approximate date(s) of surgery
Surgery ________________________ Date: ____________
Surgery ________________________ Date: ____________
Surgery ________________________ Date: ____________
Surgery ________________________ Date: ____________

Do you take any medications? (List type of medication, dosage and the manner in which you take it)
____
____

Do you have any allergies? ________________________
Have you had any injuries? ________________________
Factures: ____________ Back injuries____________ Whiplash:____________
Do you smoke? ________ Packs per day: ____________ How many years: ________
Do you drink? ________ #/Type per day: ____________ How many years: ________
Drug uses other than listed above?________________________

Any recent weight change?(Please explain): ______________________________
Any recent fever? (Please explain):______________________________
Childhood Illnesses? (Circle all that apply):
Rheumatic Fever Scarlet Fever Diphtheria Polio Other:__________

Family History

Mother: Age_____ Any diabetes, heart disease, high blood pressure? (Circle all that apply)
Father: Age______ Any diabetes, heart disease, high blood pressure? (Circle all that apply)
Brother(s)/ Sister(s): Ages/ Medical Problems:______________________________

____

____

Please circle Y(Yes) or N (No) to answer the following questions:
Have you **recently** had any of the following:

HEAD
Headaches Y N
Dizzy Spells Y N
Head Injuries Y N

NOSE
Bleeding Y N

LUNGS
Asthma Y N
Bronchitis Y N
Emphysema Y N
Cough Y N
Cough up Blood Y N

STOMACH
Loss of appetite Y N
Difficulty w/ swallowing Y N
Stomach pain Y N
Ulcers Y N
Vomiting Y N
Vomiting Blood Y N
Gallbladder Y N
Hepatitis Y N
Jaundice Y N
Constipation Y N
Diarrhea Y N
Hemorrhoids Y N
Diarrhea Y N
Change in bowel habits Y N
Hemorrhoids Y N

DERMATOLOGIC
Rash Y N
Suspicious Moles Y N

EYES
Double vision Y N
Blurred vision Y N
Glasses Y N
Contacts Y N
Cataracts Y N
Glaucoma Y N

MOUTH
Sores Y N
Dentures Y N

HEART
Chest Pain Y N
Palpitations Y N
Irregular Heartbeat Y N
Swollen Ankles Y N
Wake up short of breath Y N
Short of breath with activity Y N

ENDOCRINE
Thyroid problem Y N
Diabetes Y N
High Cholesterol Y N

GENITOURINARY
Night time urination Y N
Pain with urination Y N
Blood in urine Y N
Bladder infections Y N
Kidney stones Y N
Trouble starting urine Y N
Loss of bladder control Y N
Prostate problems Y N

EARS
Hard of hearing Y N
Ringing in ears Y N
Ear infections Y N
Discharge Y N

NECK
Chronic Pain Y N

BREAST
Lumps Y N
Pain Y N
Discharge Y N

GYNECOLOGIC
Abnormal bleeding Y N
Vaginal discharge Y N
# of pregnancies ____
# of miscarriages ____

BONES & JOINTS
Pain/swelling joints Y N
Muscle cramps Y N
Arthritis Y N
Gout Y N
Osteoporosis Y N
Back Pain Y N
Leg cramps with excercise Y N
Do fingers change Colors in the cold Y N

NUEROLOGIC
Seizures Y N
Blackouts Y N
Numbness Y N
Paralvsis Y N

Patient Signature______________________ **Date**____________

Thank you for helping us best serve your healthcare needs.

Authorization to Discuss
Health and Medical Information

PATIENT NAME: ____ DATE OF BIRTH: ___________________

PARENT OR LEGAL GUARDIAN: ______________________________________

☐ If I am not present, **I authorize** Comprehensive Pulmonary and Primary Care and staff to disclose my relevant health information with the family and/or friends named below.

☐ I **decline** to name family members and/or friends who Comprehensive Pulmonary and Primary Care and staff may discuss my health information with at this time. However, I understand that I can always verbally authorize providers and staff to discuss health information with family members and/or friends or I may complete form at a later date.

Name: ___________________________________ Relationship: ______________ Phone#:______________

Name: ___________________________________ Relationship: ______________ Phone#:______________

Name: ___________________________________ Relationship: ______________ Phone#:______________

Name: ___________________________________ Relationship: ______________ Phone#:______________

I understand that this authorization is valid and in effect until such time as I withdraw it in writing or in person, or one year following date of signature.

I understand that I can revoke, update, or change this verbal authorization at any time in writing. The termination to verbally release health and medical information is effective on the date the physician office receives it. It does not apply to any information released prior to the date of receipt of the written termination.

____ ___________________

Printed Name (Patient/Parent or Legal Guardian) Date

____

Signature (Patient/Parent or Legal Guardian)

Consent to Treatment

I consent to be treated by the medical staff at **Vista Del Mar Medical Group**, subject to my informed consent. I understand that as a patient, I have the right to be informed about my condition and any recommended medical, surgical, or diagnostic procedures to be performed and any attendant risks and hazards so that I may make the decision whether to undergo any suggested treatment or procedure.

I understand this consent provides **Vista Del Mar Medical Group** with my permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I am indicating that (1) I intend that this consent be continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. I understand I have the right at any time to discontinue services. I further understand I have the right to discuss the treatment plan with my physician about the purpose, potential risk and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I understand it is my responsibility to ask questions.

Agreement of Financial Responsibility

- A photo ID is required for all patient visits. We will ask to make a copy of your ID and insurance card for our records. Proof of insurance is required for all patients that are not paying cash at time of service. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- We require all patients to pay their copay at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards. If a check is returned for any reason, you will be charged a $25 fee in addition to the amount of the check.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Please contact your insurance company with any questions about your benefits and coverage.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- We participate in most insurance plans. If we have a contract with your insurance company we will bill your insurance company first, and then bill you for any amount determined to be your responsibility, less what was collected at the time of service (copay amount). This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, we will, as a courtesy, file a claim with your insurance carrier. Please understand some insurance coverages have out-of-network benefits that may be subject to deductibles and higher out of pocket responsibility from you. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than if you used an in-network provider. Once your insurance processes the claim, we will send you a statement for your balance due. Payment is due upon receipt of the statement.
- Please be aware that some, and perhaps al, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will provide you with an estimate of these costs should the issue present itself. We collect payment based on this estimate at the time of visit.
- Patients with an outstanding balance of 60 days or more overdue must make payment arrangements prior to scheduling future appointments. Chronic nonpayment may result in referral of balance to an outside collection agency and termination of physician services – please help us to avoid this.

I have read the **Consent to Treatment** and **Agreement of Financial Responsibility** contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Printed Name (Patient/Parent or Legal Guardian) Date

Signature (Patient/Parent or Legal Guardian) Relationship to Patient

Vista Del Mar Medical Group, Inc.

Agreement of Financial Responsibility

Thank you for choosing Vista Del Mar Medical Group, Inc. as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- A photo ID is required for all patient visits. We will ask to make a copy of your ID and insurance card for our records. Proof of insurance is required for all patients that are not paying cash at time of service. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- We require all patients to pay their copay at the time of service. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards. If a check is returned for any reason, you will be charged a $25 fee in addition to the amount of the check.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Please contact your insurance company with any questions about your benefits and coverage.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- We participate in most insurance plans. If we have a contract with your insurance company we will bill your insurance company first, and then bill you for any amount determined to be your responsibility, less what was collected at the time of service (copay amount). This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, we will, as a courtesy, file a claim with your insurance carrier. Please understand some insurance coverages have out-of-network benefits that may be subject to deductibles and higher out of pocket responsibility from you. If you receive services that are part of an out-of-network benefit, your portion of financial responsibility may be higher than if you used an in-network provider. Once your insurance processes the claim, we will send you a statement for your balance due. Payment is due upon receipt of the statement.
- Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will provide you with an estimate of these costs should the issue present itself. We collect payment based on this estimate at the time of visit.
- Patients with an outstanding balance of 60 days or more overdue must make payment arrangements prior to scheduling future appointments. Chronic nonpayment may result in referral of balance to an outside collection agency and termination of physician services – please help us to avoid this.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

______________________________	______________________________
Printed Name (Patient/Parent or Legal Guardian)	Date
______________________________	______________________________
Signature (Patient/Parent or Legal Guardian)	Relationship to Patient

NOTICE OF PRIVACY PRACTICES

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 care about our patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official note of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms and the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Office at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or healthcare operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided from each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence medication we prescribe for the treatment process.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, your insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you from health care operation to assure that you received quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other healthcare providers' treatment activities

- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMAITON REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you make revoke that authorization, in writing at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMAITON

Complaints – If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Submit your complaint to one or both of the following addresses:

Attention: Privacy Officer
Vista Del Mar Medical Group, Inc.
1200 West Gonzales Road,
Oxnard, California 93036
(805) 983.09691

Region IX; Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Right to Request Restrictions – You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications – You have the right to request how we should send communication about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this Practice.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy – You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in

writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that that the denial be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend – If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not a part of the information which you would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have a right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Non-Standard Disclosures – You have the right to request a list of the disclosures we made of medical information about you. To request a list, you must submit your request to the Privacy Officer at the practice. Your request must state the time period for which you want to receive a list of disclosures that is not longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing this list.

Right to a Paper Copy of this Notice – You have the right to a paper copy of this Notice at any time. To obtain a paper copy of the current Notice, please request on and it shall be given to you.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as information we receive in the future. We will post a copy of the current Notice, with the effective date in the header of the first page.

Acknowledgement of Receipt of Notice of Privacy Practices

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practices and for you to sign as acknowledging receipt of the document.

I understand that Vista Del Mar Medical Group, Inc. ("VDMMG") may share my health information for treatment, billing and healthcare operations. I have been provided a copy of VDMMG's Notice of Privacy Practices that describes how my health information is used and shared. I understand that VDMMG has the right to change this notice at any time.

I acknowledge receipt of the Notice of Privacy Practices of Vista Del Mar Medical Group:

______________________________	______________________________
Printed Name (Patient/Parent or Legal Guardian)	Date
______________________________	______________________________
Signature (Patient/Parent or Legal Guardian)	Relationship to Patient

AUTHORIZATION TO LEAVE MESSAGES

I authorize Vista Del Mar Medical Group, Inc. to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party listed below:

Name	Relationship	Phone #
Name	Relationship	Phone #

INABILITY TO OBTAIN AKNOWLEDGEMENT (to be completed by office staff)

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- □ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt
- □ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices
- □ Other:______________________________

______________________________	______________________________
Printed Name (Patient/Parent or Legal Guardian)	Date
______________________________	
VDMMG Employee Signature	