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Patient Registration Form

Today's Date:	Legal Name: Last First Middle	
Date of Birth: Social Security Number:	Sex Assigned at Birth: ☐Female ☐Male Gender Identity (optional): _____ Sexual Orientation (optional): _____ Preferred Pronoun (optional): _____	Marital Status: ☐ Married ☐Single ☐ Widowed ☐ Divorced ☐ Legally Separated
Email: Preferred Phone Number: Can detailed confidential messages be left at this number? ☐ Yes ☐ No ☐ I agree to receive promotional and marketing material at this number	Preferred Language: ☐ English ☐Spanish ☐ ASL ☐ Other _____ Do you need an interpreter? ☐ Yes ☐No	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ Decline to Specify ☐ Other _____
Mailing Address: Street City State Zip		Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to Specify
Preferred Pharmacy Name:	Pharmacy Phone Number:	
Pharmacy Address:		
Who is the Subscriber under your **PRIMARY** health insurance? ☐ Self ☐Spouse ☐Parent/Guardian ☐Other_____ If not "Self", please complete the following: Subscriber Name and Date of Birth: _____ If Tricare Insurance, Subscriber SSN: _____		
Who is the Subscriber under your **SECONDARY** health insurance? ☐ Self ☐Spouse ☐Parent/Guardian ☐Other_____ If not "Self", please complete the following: Subscriber Name and Date of Birth: _____ If Tricare Insurance, Subscriber SSN: _____		
Emergency Contact Name:	Emergency Contact Phone:	
Relationship to Patient: ☐Spouse ☐Parent/Guardian ☐Friend ☐ Other_____		
Do you authorize Protected Health Information (PHI) to be discussed with this individual? ☐Yes ☐No		
Is there anyone else you would like to authorize PHI to be discussed with? ☐ Yes ☐No If yes, please list: 1. _____ 2. _____ 3. _____ 4. _____		

I have entered all information to the best of my knowledge and verify that the information listed is accurate and true. I have reviewed and agree to allow Perlman Clinic to discuss my past, present and future medication and medical information as well as all other PHI with the individuals listed above. I understand that it is my responsibility to contact Perlman Clinic directly to remove an individual listed above and agree that all future additions must be made in writing and signed by me or an authorized representative.

_____ _____

Printed Name of Patient Your Name and Relationship to Patient *(if patient is under 18)**

_____ _____

Signature *(Parent/Guardian/Caregiver Signature if patient is under 18)** Date

**If not a Parent or Legal Guardian, a Caregiver's Authorization Form must be completed and executed by the Caregiver. If a minor without a Parent or Legal Guardian, the Minor Consent for Services for Qualified Medical Care Form is to be completed. The applicable form is to be shown to the medical provider, who may or may not accept same.*

The Open Payments database 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://openpaymentsdata.cms.gov.

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Patient Financial Responsibility Policy

Your current and correct insurance card must be presented at the time services are rendered. If your card is not present at the time you receive services, we may not be able to bill your coverage until it is received. If we do not receive your insurance card within 90 days of service, many insurances will no longer allow us to bill them. You may need to seek reimbursement from them directly at that point. If your coverage cannot be verified at the time of service, you will be responsible for payment for all services up front. It is your responsibility to notify us if there are any changes to your insurance, address, phone number or family status at check-in or sooner. It is your responsibility to pay for your copay and/or coinsurance at time of service. If uninsured, it is your responsibility to pay your bill in full at time of service.

Responsible Parties: If you are an adult (age 18 or older) you are legally your own responsible party. You may not name another adult (such as a spouse or parent) as financially responsible for you. In the instance that another adult agrees to take financial responsibility for you, they must sign the financial policy on your behalf. If you are signing for a minor child or a disabled adult child, you are the responsible party for any treatment that occurs until a new financial policy is in effect. Financial responsibility must be revoked in writing and a new responsible party must sign a new financial policy accepting responsibility at that time.

If your insurance does not cover any office visit, specifically but without limitation annual exams, and/or diagnostic testing, and/or treatment, you understand that you are responsible for payment of service and will make immediate, satisfactory arrangements to settle your account. Although we will bill your insurance company for services rendered, you are financially responsible for all services rendered. If payment has not been received within 60 days of billing your health plan, we will contact you for assistance. Should your health plan deny coverage for any reason, you will be responsible for payment within thirty days of your billing statement. We also charge a $30 no-show fee for appointments that are not cancelled ahead of time.

Auto Claims: In order to bill claims to Auto insurance, we must have all available information at time of service. This includes but is not limited to the name of the auto insurance, contact information for the adjuster, claims address, claim number, authorization number, policy number, name of the policy holder, date and time of accident. If this information is not provided or available, we will see you on a cash pay basis.

Worker's Compensation Claims: In order to bill Work Comp claims, we must have authorization (authorizations should be in the name of Perlman Clinic, not specific providers) from the Worker's Compensation Liability insurance company, the policy number, the date and time of injury, the name of the adjuster, claims mailing address, pre authorized services/ procedures (if applicable) and claim number. All out of state Workers' Compensation visits shall be paid in full at time of visit.

Acknowledgement and Agreement:

I have entered all information to the best of my knowledge and verify the information to be accurate and true. I have read and understand the Patient Financial Responsibility Policy. I also understand that Perlman Clinic may amend such terms from time-to-time. I authorize my insurance benefits to be paid directly to Perlman Clinic. I also authorize Perlman Clinic and my insurance company to release any information required to process my claims.

Printed Name of Patient	Patient Date of Birth
Signature *(Parent/Guardian Signature if patient is under 18)**	Date

Guarantor Information *(if person signing is not the patient)*

Printed Name of Person Signing	Date of Birth	Relationship to Patient

**If not a Parent or Legal Guardian, a Caregiver's Authorization Form must be completed and executed by the Caregiver. If a minor without a Parent or Legal Guardian, the Minor Consent for Services for Qualified Medical Care Form is to be completed. The applicable form is to be shown to the medical provider, who may or may not accept same.*

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HIPAA Compliance Requirement Form
Notice of Perlman Clinic Privacy Practices

THIS DOCUMENT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO SUCH INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to ask each of our patients to acknowledge receipt of our Notice of Privacy Practices. Perlman Clinic must take steps to protect the privacy of your Protected Health Information ("PHI") in accordance with HIPAA. PHI includes information that we have created or received regarding your health care, including payment and billing for your health care. In addition to your medical records, PHI includes personal information such as your name, social security number, address, and phone number.

This Notice of Perlman Clinic's Privacy Practices is also available on the Perlman Clinic website, www.perlmanclinic.com, under HIPAA/Privacy Practices in the Site Links. If you need a copy thereof, please ask for a copy to be provided to you. Under federal law, we are required to: (i) protect the privacy of your PHI (Perlman Clinic therefor requires our employees to maintain the confidentiality of PHI); (ii) provide you with this Notice of Perlman Clinic Privacy Practices explaining our duties and practices regarding your PHI; and (iii) follow the practices and procedures set forth in this Notice of Perlman Clinic Privacy Practices.

Perlman Clinic participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants within the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. Your health information is integrated into UCSD's electronic health recordkeeping system. The OHCA will follow the terms of this joint notice. The OHCA participants may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals. UCSD also has its own Notice of Privacy Practices that can be accessed at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.

We may disclose PHI about you to doctors, nurses, technicians, students or other health system personnel who are involved in taking care of you in the health system. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. A doctor treating you for a mental condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed to you. We may also share PHI about you with other non-Perlman Clinic and non-UC San Diego Health providers. The disclosure of your PHI to non-Perlman Clinic and/or non-UC San Diego Health providers may be done electronically through a health information exchange that allows providers involved in your care to access some of your Perlman Clinic and/or UC San Diego health records, including PHI, to coordinate services for you.

I understand that as a part of my healthcare, Perlman Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and treatment. I understand that this information serves as follows:

A basis for planning my care and treatment;
A means of communication among health professionals who contribute to my care;
A source of information for applying my diagnosis and treatment to my bill;
A means by which a third-party payer can verify services billed were provided;
A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as a part of Perlman Clinic's treatment, payment and/or healthcare operations, it may become necessary to disclose my PHI to another entity and I consent to such disclosure for these permitted uses including disclosures via fax and sharing of electronic medical records. Additionally, PHI may be released without my authorization for (i) legal and/or governmental purposes and for (ii) certain miscellaneous circumstances, such as to a person accompanying you for treatment or to an authorized public party for disaster relief purposes, all as allowed under HIPAA.

Except for the situations listed above, we will use and disclose your PHI only with your written authorization. We will not disclose your PHI in the following cases, unless you give us written permission: (i) marketing purposes; (ii) sale of your information; and (iii) most sharing of psychotherapy notes. Federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose such PHI. In these situations, we will contact you for the necessary authorization. In some situations, you may revoke your authorization. If you have questions about these laws, please contact the Privacy Officer at 858-554-1212.

Email and Text: You are advised that email and text are not secure methods of communication. If you email or text us you agree to our communication by use of email or text and you agree to the risks. If you prefer to not exchange health information by email or text, please let us know by sending an email to info@perlmanclinic.com or texting 858.554.1212.

Without limitation, you have the right to request: (i) restrictions on the disclosure of your PHI; (ii) ask for a specific means of communication; (iii) request an electronic or paper copy of your PHI; (iv) an amendment to your PHI; (v) seek an accounting of the disclosures made of your PHI; (vi) a paper copy of this Notice; and (vii) a written notification of any breach of the confidentiality of your PHI. All requests must be in writing and in certain circumstances a request may be denied or require the payment of a fee. In any such circumstances we will explain our response. You may file a complaint if you believe your privacy rights have been violated. You can file a written complaint with us and/or with the U.S. Department of Health and Human Services Office for Civil Rights. Their address is 200 Independence Avenue, S.W., Washington, D.C. 20201. You may also contact them by calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I hereby agree to the above and consent for Perlman Clinic to obtain my past, present and future medication and medical information as well as all other PHI:

Patient Name	Patient Date of Birth
Signature *(Parent/Guardian Signature if patient is under 18)**	Date
Printed Name of Person Signing	Relationship to Patient

**If not a Parent or Legal Guardian, a Caregiver's Authorization Form must be completed and executed by the Caregiver. If a minor without a Parent or Legal Guardian, the Minor Consent for Services for Qualified Medical Care Form is to be completed. The applicable form is to be shown to the medical provider, who may or may not accept same.*

THIS WILL BE FILED WITH YOUR MEDICAL RECORDS

Medical History Questionnaire

Today's Date:	Legal Name: Last First Middle

Please tell us the reason(s) for your visit:

_____

_____

List any medication(s) you are allergic to:

_____reaction _____ _____reaction_____

_____reaction _____ _____reaction_____

List all medication(s) you are currently taking, including non-prescription / herbal products:

_____ dosage_____frequency _____ _____ dosage_____frequency _____

_____ dosage_____frequency _____ _____ dosage_____frequency _____

_____ dosage_____frequency _____ _____ dosage_____frequency _____

_____ dosage_____frequency _____ _____ dosage_____frequency _____

List any prior surgeries (type and year)

_____

_____

_____

_____

List any prior hospitalizations (why and how long)

_____

_____

_____

_____

Over the last 2 weeks how often have you felt the following:

1. Little interest or pleasure in doing things	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
2. Down, depressed or hopeless	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day

Last pap smear date and result:_____

Last mammogram date and result:_____

Last colon cancer screening date and result:_____

Personal Sexual Activity (Check all that apply)

Sexually Active:	☐ Yes	☐ Not Currently	☐ Never			
Birth-control / Protection:	☐ Condom	☐ Pill	☐ Nexplanon	☐ IUD	☐ Surgical	☐ Ring
Partners:	☐ Male	☐ Female				

Personal Medical History (Check all that apply)

☐ A Fib	☐ Clotting Disorder	☐ Glaucoma	☐ IBD
☐ Anemia	☐ COPD	☐ Heart Disease	☐ Migraine
☐ Arthritis	☐ Depression	☐ HIV/AIDS	☐ Obesity
☐ Asthma	☐ Diabetes	☐ Hypercholesterolemia	☐ OSA (Obstructive Sleep Apnea)
☐ CAD	☐ DVT	☐ Hypertension	☐ Pneumonia
☐ CHF	☐ GERD	☐ Hypothyroidism	☐ Seizures

Family Medical History (Check all that apply)

	No Known Problems	Cancer	Diabetes	Heart Disease	Hypertension	Psychiatry	Stroke	Thyroid	Other
Mother									
Father									
Sister									
Brother									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									