521 N WILMA AVENUE STE A
RIPON, CA 95366

TELEPHONE 209-599-4211
FAX 209-599-7348

www.RiponFP.com

Date_____

Last Name_____ **First Name**_____ **MI**____

Date of Birth_____ **Gender: M / F** **Social Security #**_____

Address_____ **City**_____ **State**____ **Zip**_____

Mailing Address (if different) _____

Primary Phone_____ **Alternate Phone**_____

Email_____ **Communication Preference:** □ Phone □ Mail □ Portal

Occupation_____ **Employer**_____ □**Retired** □**Student**

Preferred Pharmacy_____

Preferred Language_____ **Other Languages Spoken**_____

Race: □White □Black □Asian □Hawaiian □Pacific Isle □American Indian/Alaskan □Other_____

Ethnicity: □ Non-Hispanic □ Hispanic

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Emergency Contact_____ **Phone**_____ **Relationship**_____

Emergency Contact_____ **Phone**_____ **Relationship**_____

Primary Insurance_____ **ID#**_____

Secondary Insurance (if applicable):____ _____ **ID#**_____

Policy Holder Name (if different from patient) _____ **Relationship**_____

Policy Holder's Birthdate_____ **Policy Holder's SS#**_____

Other Family Members in Household (if applicable):

Spouse Name_____ **Parent's Names**_____

Children _____

How did you hear about us? □ **Insurance** □ **Website** □ **Referred by** _____

RIPON FAMILY PHYSICIANS

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AUTHORIZED CONTACTS

Patient_____ **Birth Date**_____

I give permission for the office staff to speak to and share detailed information regarding my medical care with the following individuals:

Name: _____Phone:_____Relationship to patient: _____

If applicable: ☐Emergency Contact ☐Durable Power of Attorney for Healthcare *(provide copy)*

Name: _____Phone:_____Relationship to patient: _____

If applicable: ☐Emergency Contact ☐Durable Power of Attorney for Healthcare *(provide copy)*

Name: _____Phone:_____Relationship to patient: _____

If applicable: ☐Emergency Contact ☐Durable Power of Attorney for Healthcare *(provide copy)*

☐ **NO AUTHORIZED CONTACTS**

Signature of Patient/Guardian/Representative_____Date_____

If this authorization is NOT signed by the patient, complete the following information:

Printed Name_____ Relationship to Patient_____ Representative's Phone # _____

RIPON FAMILY PHYSICIANS

Medical Records Release Form

Please fax my records from:

_____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

I hereby authorize that you release my medical records to: Ripon Family Physicians
521 N Wilma Ave Ste A ● Ripon, CA 95366 ● Phone: 209-599-4211 ● Fax: 209-599-7348

PRINT Patient's Full Name: _____

_____	_____	_____
Date of Birth	Phone Number	Medical Record #, if known

_____		
Address	City	State & Zip

SPECIFIC REQUEST:

☒ *Chart Summary, Problem List, Surgical History, Current Medications/Allergies*
☒ Progress notes (1 year)
☒ Immunization Record
☒ Most recent labs
☒ Colonoscopy/Endoscopy + pathology (adults)
☒ Most recent Pap smear pathology (women)
☒ Most recent Mammogram (women)

☐ Drug/Alcohol/Substance abuse records
☐ Psychiatric records
☐ HIV/STD results
☐ Genetic Information

OTHER _____

Purpose: At the request of the individual.
This authorization is effective immediately and will remain in effect for one year from the date of signature, unless a different date is specified here: _____. The recipient of this protected health information will not re-disclose the information, except with a written authorization or as specifically required or permitted by law. Upon request, the patient will receive a copy of this completed authorization form. This authorization is subject to written revocation by the patient at any time. A copy of this authorization is as valid as the original.
The covered entity may not condition treatment or payment upon whether the individual signs the authorization.

_____		_____
Signature	Date	Relationship to patient, (if different)

Faxed: Date & Initials

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New Patient Past Medical History Form

Patient_____ **Birth Date**_____

Your answers on this form will help us understand your medical concerns and conditions better.

Personal Medical History

Please indicate if you have had any of the following problems currently or in the past.

- ☐ Anemia
- ☐ Asthma/Emphysema
- ☐ Cancer/tumors
- ☐ IBS
- ☐ Depression
- ☐ Diverticulosis
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Gallstones
- ☐ Gout
- ☐ Heartburn/Acid Reflux
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney disease/stones
- ☐ Liver disease/Hepatitis
- ☐ Lung disease/pneumonia
- ☐ Pancreatitis
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Venereal disease/Syphilis
- ☐ Thyroid disease/goiter
- ☐ Tuberculosis
- ☐ Ulcers (stomach or intestinal)

If yes to any of the above, please explain_____

_____

_____

Medication

Please list all your current medications, including medications and supplements not needing a prescription:
Or attach a complete list. ☐ **On No Medications**

Medication	**Dose**	**Directions**	**Taken For:**	**Will our office be refilling?**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**
_____	_____	_____	_____	☐ **Yes** ☐ **No, refilled by specialist**

Allergies ☐ **No Drug Allergies**

Please list any allergies or reactions to medications:

Medication	Reaction or Side Effect
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History (include type, body part, date): ☐ **No significant surgeries**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History ☐ **Adopted**, family history unknown.

Has anyone in your family (including grandparents, parents, brothers, sisters, or children) had any of the following conditions?

			Family Relationship:		
Bowel/Colon Cancer	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Breast Cancer	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Depression	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Diabetes	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Heart Disease	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
High Blood Pressure	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
High Cholesterol	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Kidney Disease	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Rheumatoid Arthritis	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Strokes	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Thyroid Disorder	☐Yes	☐No	_____	☐Living	☐Deceased at age_____
Other_____	☐Yes	☐No	_____	☐Living	☐Deceased at age_____

Personal Habits

Tobacco Use: Cigarettes: ☐Never ☐Former ☐Current Smoker (Packs per day___ # of Years___ Quit-Date___)

Other tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew Are you interested in quitting? ☐Yes ☐No

Do you drink alcohol? ☐ Yes, average # of drinks per week___ ☐ No (If no, have you in the past? ☐Yes ☐No

Do you use any recreational drugs, such as marijuana, cocaine, stimulants, narcotics, diet pills? ☐No ☐Yes

(please circle which drugs) Have you ever used needles? ☐Yes ☐No

Are you sexually active? ☐No ☐Not currently ☐Yes – If yes, do you practice safe sex? ☐Yes ☐No

Birth control method_____

Have you ever had any sexually transmitted diseases (STD's)? ☐No ☐Yes_____

Do you exercise regularly? ☐Yes ☐No How many times per week? _____

If yes, what type of exercises?_____

Woman's Health (if applicable)

Total # of pregnancies_____ # of deliveries_____ # of miscarriages_____ # of abortions_____

Age at start of menstrual period _____

Date most recent period began (LMP) _____ Usual length of period _____ days

Have you stopped having menstrual periods? ☐No ☐Yes If yes, when_____

Date of last Pap smear _____ Have you ever had an abnormal Pap smear? ☐No ☐Yes

If yes, give date and describe _____

If you see a gynecologist for your annual exams, please list their name/phone: _____

Do you have regular problems with:

☐ Irregular periods ☐ Bleeding between periods ☐ Hot flashes

☐ Painful periods ☐ Bleeding after menopause ☐ Breast pain/lump

☐ Heavy periods ☐ Vaginal discharge or itching

RIPON FAMILY PHYSICIANS

OFFICE INFORMATION AND POLICY AGREEMENT

Patient Name: _____ Patient DOB: _____

Welcome to the family practice office which has served Ripon and surrounding communities since the early 1970's. Thank you for coming to us for your health care needs. We look forward to providing you with quality medical care. The following information will help familiarize you with our office.

For New Patients
Our doctors request that prior to a new patient's first appointment, past medical records be transferred to our office in order to effectively manage your care.

Appointments
Office Appointments are available from 7:00AM – 4:00PM Monday - Thursday and 7AM – 11:30AM on Friday. Phone hours are from 8-12 and 1-5, Monday - Thursday, and from 8-12 on Friday. We try to offer same-day appointments, but these are booked quickly, so we advise that you call the office early in the day if you hope to schedule a same-day appointment.

Please inform the schedulers of the reason for your appointment so they can allow adequate time for your appointment. Bring your insurance card, copay, and a list of your current medications with you to each appointment.

Should you be unable to keep your appointment, please call us at (209)599-4211 to cancel or reschedule, *as soon as possible*. There will be a $50 charge for missed appointments.

Medication Refills
Please contact your pharmacy directly when due for a medication refill. They will forward your request to us and we will respond within 48-72 hours.

Referrals
In the event your provider feels it is necessary refer you to a specialist, we ask that you give our office 7-10 business days to process the referral. If you have not heard from us or the specialist's office after that time, please call our office to check on your referral.

Consent to Communication
You consent to receive communications via phone, voicemail, secure text messages, portal and any other electronic HIPAA compliant platforms, for purposes including but not limited to appointments, healthcare reminders, pre-registration, prescription information, and billing information. I understand that depending on my phone plan, I could be charged for these calls or text messages.

Family Medical Leave Forms/Short- and Long-Term Disability Forms, etc
At times insurance carriers or employers may require additional paperwork to assist you with your healthcare needs. As these forms are time consuming Ripon Family Physicians reserves the right to charge a fee for any type of affidavits, letters, or forms requested by the patient. Payment for these forms is due at the time of services. An office visit or appointment may be necessary to complete the forms. Please allow 5-7 business days for completion of requested forms.

Health Information Exchange
Ripon Family Physicians participates in electronic exchange networks and some of the uses and disclosures of information may be done through electronic means, such as a Health Information Exchange (HIE). Other entities may access your health information for treatment or other permitted uses.
Example: Health information may be securely exchanged between your treating healthcare providers at different organizations to coordinate your care.

Audio or Video Recording
In the interest of your privacy, as well as that of our workforce, *unauthorized* audio or video recording by patients, family members, and/or visitors is strictly prohibited. To the extent a member of our workforce is aware of any *unauthorized* attempt to photograph or record a patient and/or workforce member, the workforce member will take reasonable steps to ensure that patients and/or workforce members are not photographed within the office. We respectfully request that you turn off or silence your cell phone during your office visit.

Dismissal Policy
Ripon Family Physicians reserves the right to dismiss patients for reasons including but not limited to:

-failure to keep appointments
-non-compliance
-verbally or physically abusive to staff
-abuse of prescription drugs and/or failure to comply with narcotic refill policy
-failure to meet financial obligations

You will be notified via certified mailed of your dismissal and after thirty days will no longer be seen at Ripon Family Physicians. We will provide emergent care only during the 30 days from the date of the letter.

Open Payments Database is a federal tool used to search payments made by drug and device companies physicians and teaching hospitals. It can be found at:
https://openpaymentsdata.cms.gov.

I hereby acknowledge that I have received and agree to the Office Information and Policy Agreement for Ripon Family Physicians.

Patient Name: _____

Signature of Patient or Responsible Party: _____ **Date Signed:** _____

RIPON FAMILY PHYSICIANS

FINANCIAL POLICY AGREEMENT

Patient Name: _____ Patient DOB: _____

Patient Consent for Treatment

I voluntarily consent to any and all heath care treatment and diagnostic procedures provided by Ripon Family Physicians and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of treatments or examinations at Ripon Family Physicians.

Financial Policy

Assignment of Benefits & Release of Information

I hereby authorize treatment of myself or the minor described above. I hereby authorize Ripon Family Physicians to release my medical information to facilitate payment and coordination of care for rendered services. I authorize payment from my insurance company be assigned to Ripon Family Physicians. I understand that I am ultimately responsible for the balance of my account. I authorize the release of all medical information necessary for Ripon Family Physicians to meet State and Federal reporting requirements. If receiving medical services for employment, I authorize the release of the results of my exam to my employer. I authorize Ripon Family Physicians to obtain all of my immunization/ medication/prescription history when using an electronic system to prescribe medications and obtain immunization history. I acknowledge that I retain the right to review Ripon Family Physicians Notice of Privacy Practices in the office upon request.

Missed Appointments: A missed appointment fee of $50.00 may be charged if you do not show up for a scheduled appointment. This fee must be paid before a new appointment is scheduled. You may be discharged from Ripon Family Physicians if you have more than 3 missed appointments.

Account Balances: Patient account balances are due within 30 days of the receipt of the billing statement. Balances must be paid prior to services being rendered. If you are unable to pay your balance in full, we will reschedule your appointment until payment arrangements have been established. If you have failed to make appropriate payment arrangements after 2 billing statements, your account may be turned over to an outside collection agency. If you have established a payment plan and fail to meet agreed upon terms, your account may be turned over to an outside collection agency.

Accounts turned over to an outside collection agency may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find alternative care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

Non-Emergency Appointments: we reserve the right to reschedule non-emergency appointments if there is an overdue balance on your account or if co-payment is not made at the time of service.

Returned Checks: There is a $40.00 fee for returned checks. This fee plus your balance is due when you are notified of the returned check.

Insurance: Ripon Family Physicians participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan and the physician you will be seeing is in network with them. A valid driver's license or state issued ID and insurance cards must be presented at each visit. If you do not have your up-to-date insurance card, we will be happy to reschedule your appointment or classify your appointment as self-pay.

Self-Pay: self-pay patients are required to pay for services in full prior to leaving.

It is your responsibility to inform us in a timely manner of any changes to your billing and insurance information. If an insurance company denies payment for incomplete or wrong information, it is your responsibility to make payment in full. Please be aware there is a time limit on how long we have to file insurance claims. If we miss the deadline because you did not provide us with the correct information, you will be responsible for payment in full. We request your assistance in following up with your insurance company to resolve any non-payment issues. It is your responsibility to pay the bill. If we have not received payment from your insurance company within 45 days of the date first billed, you may be expected to pay the balance in full.

Please be aware that some and perhaps all of the services you receive may be non-covered by your insurance carrier. You are responsible for any and all portions of the bill not covered by your insurance plan. Co-pays must be paid prior to services being rendered. Your Insurance Company may deny the claim if co-pays are not collected and you may be responsible for the entire charge. To prevent this, if you are unable to pay your co-pay, we may have to reschedule your appointment. Patients who are unable to pay for the services as required by their insurance will be required to speak with an account representative to set up a payment plan.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

I hereby acknowledge that I have received the Financial Policy Agreement for Ripon Family Physicians.

Signature of Patient or Responsible Party: _____ Date Signed: _____