ADVANCED MEDICAL CARE CENTER, LLC
INSURANCE INFORMATION FORM

Welcome to our practice. As a new patient, please complete the following information to the best of your ability.

Patient Information:

Last Name	First Name	Middle Initial
Street Address	City/State/Zip Code	Social Security #
Phone Number/Other	Date of Birth	Male or Female
Cell Phone	Email	Marital Status S / M / D / W
Emergency Contact Name/Phone #	Pharmacy Name & Phone #	

Employer Information:

Name	Work Number	Occupation
Address	City/State/Zip Code	

Insurance Information:

Name of First Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	
Name of Secondary Insurance Company			
Street Address	City	State	Zip Code
Insurance ID Number		Local/Group Number	

Subscriber Information: (Policyholder if different from patient)

Relationship to Patient	Name	Date of Birth
Social Security	Address	Zip Code
Home Number	Employer's Name	Work Number

I understand that if this or any other visit precedes the effective date of my insurance, or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visits. I hereby authorize payment directly to my medical provider with Advanced Care Medical Group, INC for any medical benefits payable to me under the conditions of my policy for services rendered at Advanced Medical Care Center, LLC. I hereby give consent to release to authorized persons financial and medical information concerning care, treatments and charges as may be required to complete all claims for benefits.

Signature of Patient or Authorized Representative:	**Date:**

Gina Mayo, HIPAA Privacy and Security Officer
Advanced Medical Care Center, LLC
3130 W Caldwell Ave.
Visalia, CA 93277
559-635-7800 Fax 559-635-7805

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Advanced Medical Care Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Advanced Medical Care Center has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Advanced Medical Care Center will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Advanced Medical Care Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Advanced Medical Care Center has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Advanced Medical Care Center.

FORM Us

ADVANCED MEDICAL CARE CENTER, LLC

Acknowledgement of Receipt of Patient Health Care Rights & Responsibilities, Advance Directive Policy, Ownership Disclosure and Consent for Treatment

I acknowledge that I have received a copy of Advanced Medical Care Center's:

1. **Patient Health Care Rights & Responsibilities,**

2. **Advance Directive Policy and Procedure,**
   An "Advance Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. If you have an Advance Directive please notify AMCC and provide a copy to be kept in your medical record.

   It is the policy of Advanced Medical Care Center, for all patients, regardless of the content of Advance Directive, that if an adverse event occurs during treatment at AMCC, the personnel will initiate resuscitative or other stabilizing measure and transfer to an acute care hospital for further evaluation, Cal. Probate Code 4735-4736. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with the patient's wishes, advance directive, or health power of attorney.

   If you would like a copy of the official State Advance Directive forms, visit http://www.calhospital.org/sites/main/files/file-attachments/forms3.pdf , or speak to your provider today for further information and receive an information packet.

3. **Ownership of Advanced Care Medical Group, Inc and Advanced Medical Care Center, LLC**
   As a patient, you have the right to be informed of all Providers that have ownership in this facility. If you receive a referral from this office, you have the right to obtain referral services from Providers other than the Providers listed below as owners. Upon the time of referral, a list of providers who furnish the same services in your area will be provided.

Advanced Care Medical Group, Inc	**Advanced Medical Care Center, LLC**
Owners	**Owners**
William C. Holvik, MD NPI 1346225364	Shawn F. Cardoza, FNP NPI 1104937002
Shawn F. Cardoza, FNP NPI 1104937002	Paul R. Mayo, DPM NPI 1396002887

4. **Consent to Medical Treatment**
   I consent to the evaluation and treatment by an Advanced Care Medical Group, INC Provider. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may provide health benefits, but they may also involve significant risks. I acknowledge that no guarantees have been made to me regarding the results of the evaluation and treatment. I acknowledge that I have the right to actively participate in decisions regarding my care, including the right to provide informed consent or to refuse any proposed treatment, directed by my provider.

I certify that I have read the foregoing and that I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign and accept the terms on his/her behalf.

Patient Signature: _____ **Patient Name:** _____ **Date:** _____

If signed by the patient's personal representative:

Representative Sign: _____ **Relationship to Patient:** _____ **Date:** _____

AMCC Office Staff Signature: _____ **Date:** _____

ADVANCED MEDICAL CARE CENTER, LLC
FINANCIAL AND BILLING POLICIES

Thank you for choosing Advanced Medical Care Center, LLC for your health care needs. For your convenience, our medical group, Advanced Care Medical Group INC participates with a variety of insurance plans and will directly bill your insurance under these plans.

It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. It is the patient's responsibility to know your insurance coverage. Your insurance company will only pay for services that are covered under your insurance policy, with no exceptions. If you have any questions, call your health plan's member services department. Their number should be listed in your benefit plan booklet or on your ID card.

Inform us of Changes:
If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit.

Bring your Health Insurance Information and Photo ID:
Bring your photo ID and all insurance cards on the day of your visit. If you do not have your insurance information available at the time of service, the full office visit fee will be due at the time of service. NO EXCEPTIONS. We will later file that date of series for you and upon receipt of an insurance payment we will refund any overpayment due to you. **We are not contracted with straight Medi-Cal, or any Medi-Cal managed care plan**, and therefore do not accept, nor bill, any service to Medi-Cal or Medi-Cal managed plans under any circumstances.

I understand that Advanced Medical Care Center, LLC and Advanced Care Medical Group, INC does not bill for the services of pathology, laboratory and/or imaging services, and that I will receive a separate bill for these services. I authorize the release of pertinent medical information to my insurance company to obtain authorization for the necessary procedures or to facilitate payment of a claim.

Co-payments, Deductibles and Coinsurance:
Co-payments are due at the time of your office visit. Under the terms of our contract with the various insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, debit, VISA, MasterCard and Discover.

Deposits:
For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full, prior to treatment.

Patient Responsibility Balances:
All patient responsible balances must be paid in full upon receipt of your statement. You should have already received an explanation of benefits from your insurance carrier. By this time, at least 30 days has passed since your visit and payment of balance is your responsibility.

Who can Discuss a Bill?
Confidentiality is important. Our Medical Billing Specialist may only speak with the patient, or the person designated in writing by the patient to receive the bill(s), on behalf of the patient. Thank you for understanding our billing policies. All billing inquiries are handled by our biller. If you should have any questions regarding your bill or the status of your account, please contact our biller at **559-636-1586.**

I have read, understand, and agree to the above billing policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibilities.

I authorize my insurance benefits be paid directly to medical provider with Advanced Care Medical Group, INC and authorize the release of pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform Advanced Medical Care Center, LLC of any changes regarding my personal billing information or my insurance billing information.

Advanced Care Medical Group, INC reserves the right to bring action for the entire balance owed on my account, if default in payments is made.

_____ _____ _____

Patient Signature/Responsible Party Name Printed Date

AMCC Representative Witness:_____ Date_____

Advanced Medical Care Center

Advanced Medical Care Center will be charging a $50.00 service charge for all appointments that are NOT cancelled 24 hours in advance.

I,_____, understand that if I fail to call and cancel my appointment 24 hours in advance, I will be charged a $50.00 service charge.

Advanced Medical Care Center, LLC

Health History Form

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Pharmacy Name and Phone Number: _____

Reason for Today's Visit: _____ Effective Side (if applicable) _____

Associated Signs & Symptoms: _____

Duration of the Problem: _____

List any allergies to Medications, Latex and/or Foods, Include Reaction to Each:

□ No Known Allergies

_____

Review of Systems: Please Circle Any **Current** symptoms below:

General Symptoms:
Fever, unexplained tiredness, swollen glands, excessive thirst, feeling unusually hot or cold, easy bruising or bleeding, passing out.

Eyes:
Vision, loss, eye pain, blurred vision

Ears/Nose/Mouth & Throat:
Sore throat, runny nose, hearing loss, problems with mouth, voice changes.

Breasts:
Lumps, skin changes, nipple discharge

Lungs & Heart:
Chest pain/pressure, irregular heartbeat, cough, wheezing, breathing problems

Skin:
Rashes, changes moles, changes in hair/skin/nails

Men Only:
Difficulty starting or weak stream, difficulty getting/maintaining an erection, feeling like bladder won't empty, getting up at night to urinate, testicular pain/lumps/swelling, possible sexually transmitted infections.

Neurological:
Unusual or new headaches, weakness or numbness, falling

Abdomen:
Nausea, vomiting, pain, heartburn, diarrhea, constipation, bloody stools

Sleep:
Difficulty falling asleep, frequent awakening.

Musculoskeletal:
Joint/muscle pain, muscle weakness

Mood:
Worry too much, felt down and depressed in the last two Weeks, loss of desire to do things you used to enjoy, thoughts of self-harm or suicide.

Other:
List any symptoms not mentioned

_____

_____

_____

Women Only:
Heavy periods, bleeding after menopause, sexual concerns, unusual vaginal discharge, possible sexually transmitted infections, severe pain with periods, leaking urine.

Menstrual Cycle Questions:
Still having cycle? □No □Yes
□Regular □Irregular
Date of Last Period: _____
Birth Control Type: _____
Hysterectomy: □No □Yes
If yes, what age? _____
Due to what? _____
Number of Pregnancies:
Vaginal Deliveries _____
C-Section Deliveries _____
Other _____
Diabetes in pregnancy? □No □Yes
Have you ever had an abnormal pap or colposcopy? □No □Yes

Past Medical History: Have you **ever** been treated for any of the following medical conditions?

- □ No Known Medical Problems
- □ Seasonal Allergies
- □ Anxiety
- □ Asthma/COPD
- □ Atrial Fibrillation
- □ Depression
- □ Diabetes
- □ Cancer (Type)_____
- □ Arthritis
- □ Gastric Reflux
- □ Heart Disease
- □ High Cholesterol
- □ Hypertension
- □ Thyroid Disorder
- □ TIA/Stroke
- □ Kidney Disease
- □ Back/Joint Pain
- □ Liver Disease
- □ Dizziness/Vertigo
- □ Migraines
- □Other Conditions not listed:

_____

_____

_____

List Previous Hospitalization/Surgeries/Serious Illness and Date of Event: □ None

_____

_____

_____

List All Medications: (Include dose, frequency and over the counter medications/supplements):
□ None

_____

_____

_____

_____

_____

Refill Needed on Any Medications? □ No □ Yes, _____

Family History: Include history of diabetes, heart disease, hypertension, colon/breast/ovarian cancer, other cancers, autoimmune disease, depression, and osteoporosis.

Relative:	Health History	Alive/Deceased
Mother:		
Father:		
Sister/Brother:		
Children:		

Social History:

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

Children: □No □Yes Ages:_____

Alcohol Use: □No □Yes Number of Drinks/Frequency:_____

Tobacco Use: □Never □Currently Smoke: __pack(s) per day for___years
□Previously Smoked: pack(s) per day for___years, Quit ___
□Chewing Tobacco for _____years, Quit_____

Caffeine Use: □None □1-3 servings/day □4-6/day □ >6/day □Type:_____

Drug Use: □None □Marijuana □Cocaine □Heroin □Other:_____

Exercise: □None □Days per Week ____ Type of Exercise:_____

Trouble Sleeping: □No □Yes Occupation:_____

Preventative Screening:

Do you wear seatbelts/helmets?
□ No □Yes □Sometimes

Do you wear sunscreen?
□ No □Yes □Sometimes

Do you have an eye exam at least every two years?
□ No □Yes

Do you have a dental exam at least yearly?
□ No □Yes

When was your last: (year)
Colonoscopy_____
Lipid Panel_____
Fasting Glucose:_____HgbA1c_____

When was your last immunizations for (year):
Tdap (Tetanus,Diphtheria,Pertussis):_____
Influenza (Flu):_____
Pneumovax (Pneumonia):_____
Prevnar (Pneumonia):_____
Gardasil (HPV):_____

Women:
Date of Last:Pap Test:_____
Mammogram:_____YR _____Location
Chlamydia Screening:_____
Bone Density:_____
Any history of abnormal findings with tests in past?
□ No □Yes, _____

Men:
Date of Last PSA Screening_____
Date of Last Prostate Exam_____

Do you have an Advanced Directive? □ No □Yes
If yes, please provide the office with a copy for your records.
If no, would you like an information packet concerning Advanced Directive? □ No □Yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

I hereby give consent for medical treatment to the care providers with Advanced Care Medical Group, Inc. to care for myself, or I am authorized by the patient as his/her general agent to give consent for such treatment.

_____ _____ _____
Signature of Patient/Guardian Print Name and Relationship if Representative Date

Advanced Medical Care Center
Privacy Officer, Gina Mayo
3130 W, Caldwell Ave
Visalia, CA 93277

Authorization to Disclose Protected Health Information

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:** Specify Provider/Organization/Individual and Address
Advanced Medical Care Center 3130 W, Caldwell Ave Visalia, CA 93277	Name:_____ Address:_____ _____ _____

By Signing this Authorization, I aujthorize my Health Care Provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE:

PATIENT'S FULL NAME: _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH ____/____/____ **LAST 4 DIGITS OF SOCIAL SECURITY #** _____

ADDRESS _____
Mailing Address, City, State and Zip

_____

COVERING THE PERIOD(S) OF HEALTH CARE:
From (Date) ____/____/____ TO (Date) _____/_____/_____

1. Information Authorized For Disclosure, included in my records:

- ☐ Complete Health Record
- ☐ Visit/Discharge Summary
- ☐ Clinical Documentation of Physical
- ☐ Documentation of Consultation
- ☐ Immunization Records
- ☐ Progress Reports
- ☐ Radiology and Diagnostic Imaging Reports
- ☐ Photographs, Videos, Digital or Other Images
- ☐ Pathology Reports
- ☐ Laboratory Tests (Please Specify):
- ☐ Other (Please Specify):

2. **Right to Request Confidential Communications:** I authorize disclosure of my protected health information to be disclosed in the following communication form:

- ☐ Verbally (Over-the-Phone, **after confirming my identifying information provided in this release)**
- ☐ By Phone, at the following number:_____ Cell/Work/Home (Circle One)
- ☐ By Fax, at the following number:_____ Home/Work (Circle One)
- ☐ By Mail, Send a hard copy to the following address:_____

_____

- ☐ Electronically, at the following e-mail address:_____

3. **If applicable, I also give permission** for the following "Sensitive Protected Health Information" to be disclosed **(please initial below)**:

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- ☐ Behavioral Health Services/ Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic Counseling/Testing

_____ **I understand** that the information disclosed pursuant to this authorization, except information
Initial protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

4. **I understand** that I have a right to revoke this authorization at any time. **I understand** that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **I understand** that the revocation will not apply to information that has already been released in response to this authorization. **I understand** that the revocation will not apply to my insurance company when the law provides my insurer the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

(Date)____/____/____. **If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (initial here_____) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

5. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: Patient- (or Legal Representative, Parent or Legal Guardian) (Relationship if not Patient)

ID Provided_____ **Date**____/____/____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and or court.