



Naples Medical Group

ProHealth Partners Patient Information Sheet

PATIENT INFORMATION (please print)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: M F Marital Status: S M D W Other _____ How did you hear about us? _____

Primary Language _____ Interpreter Required: Yes No

Gender Identify: Identifies as Male Identifies as Female Female-to-Male Male to Female Genderqueer

Neither Exclusively Male nor Female Other Choose not to disclose

Sexual Orientation: Lesbian Gay or Homosexual Straight or Heterosexual Bisexual Other Don't Know

Choose not to disclose Race _____ Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____ Emergency

Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial _____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION (please print)

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: Self Spouse Child Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: Self Spouse Child Other: _____



Naples Medical Group

Pharmacy Information/ePrescribing (please print)

Pharmacy Name _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): _____ Date: _____

Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status of notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up, or partially filled.

By signing the consent form you are agreeing that (Insert Physician Name) /ProHealth Partners can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to (Insert Physician Name)/ProHealth Partners to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Emergency Contact Information

Please list two people who do not live with you that we may call in case we are unable to reach you and we have an urgent matter to discuss with you.

Note: NO CONFIDENTIAL INFORMATION SHALL BE DISCLOSED, SIMPLY TO REQUEST TO HAVE YOU CONTACT OUR OFFICE.

Emergency Contact Name	Relationship	Phone Number

Authorization to Communicate Patient’s Medical Information

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name of Person Authorized to received information	Relationship to patient	All	Medical	Appt. Only	Billing Only

Office No Show Policy

In order to assure the best appointment availability to our patients, we ask that you notify us at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule the appointment. Failure to give us 24 hours notice will result in a \$25.00 No Show fee.

Copayments, Deductibles and Share of Cost

Please note that we have a contractual agreement with your insurance company that states we are required to charge you for any deductibles, copayments and out of pocket share of cost. As a courtesy to our patients, we will bill your insurance company for services rendered in our office, however, we do ask that copayments, out of pocket share costs and deductibles that are due. Be paid at the time of service. We are no longer able to bill for these items. Any special arrangements must be made in advance with the office manager or provider.

Informative Required Information

Advance Directive given: Yes No Initials: _____ TB Risk Assessment given: Yes No Initials: _____

Signature (Patient or Parent of Minor): _____ Date: _____

Identification Policy

In effort to comply with HIPAA regulations, our office requires that you present a Picture ID and your Insurance Card at every visit.

Patient Printed Name: _____ Date of Birth: _____

Signature (Patient or Parent of Minor): _____ Date: _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of PROHEALTH PARTNERS, INC., financial policy and agree to the terms of payment due.

AUTHORIZATION TO RELEASE INFORMATION I authorize release of my medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state, and local laws. I further authorize any other individual or entity that has provided health care to me to release to PROHEALTH PARTNERS, INC., any and all of my medical records information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to PROHEALTH PARTNERS, INC., for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to PROHEALTH PARTNERS, INC., are not paid according to this financial policy, the account shall be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all cost incurred on the collection of my account, including court cost and reasonable attorney's fee. If the debt is assigned to a third-party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

MEDICAL DEBT – 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.

Patient's Signature Date

Responsible Party Relationship to Patient

Naples Medical Group Policy Acknowledgement
Effective 5/1/20

We attempt to refer you to providers, labs & x-ray facilities that are members of most health plans. However, there are more than 100 plans for which we are providers and it is not possible for us to know the details of all these plans.

It is your responsibility to know the details of your health plan.

If you are in doubt as to whether a procedure, lab test or x-ray is covered, or unsure as to where it must be performed please call your member service department and check with them.

This office will not be responsible for out-of-pocket expenses incurred from using the wrong provider or undergoing non-covered test or procedures.

Whenever you have a change in insurance please notify our office as soon as possible. It will not be the office responsibility if we have a wrong insurance card. **Initial** _____

No Show Policy: Please be advised that there will be a \$25 copay for missed appointments that are not cancelled in advance. **Initial** _____

Lab Charges: Naples Medical Group now has an independent lab sharing space in our office. As always, there will be no service charges for drawing your blood at your insurances contracted lab. For your convenience, they can draw your blood work at our office, but it will require a service charge of \$10.00 to cover expenses not covered by your insurance. **Initial** _____

Fees for Forms: Due to the ever increasing costs, it is now necessary to charge for all forms being dropped off for completion by the physician that are non-related to an office visit. Please be prepared to pay this fee when the form is brought into the office. Forms are not paid for by any insurance company. Please inquire with staff for any questions about this policy.

- State Disability \$35.00
- FMLA/Work Leave Form \$35.00
- Home Health Agency \$55.00
- Life Insurance \$25.00
- Jury Duty \$25.00
- DMV (Handicap Place Card) \$25.00
- Letter from the Doctor \$40.00
- Misc. Forms \$25.00 - \$55
- Physical Form \$25.00
- Specialty Letter for Attny/Ins. \$100.00

Initial _____

Signature: _____

Date: _____

Print Name: _____

Relationship to Patient: _____

HISTORY OF PAST ILLNESS: Have you had...

Childhood:

- | | | | | | |
|-------------------------------------|--|-------------------------------|--|-----------------------|--|
| Measles | <input type="checkbox"/> No <input type="checkbox"/> Yes | Mumps | <input type="checkbox"/> No <input type="checkbox"/> Yes | Chickenpox..... | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Strokes | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cancer | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Rheumatic fever or heart disease .. | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tuberculosis | <input type="checkbox"/> No <input type="checkbox"/> Yes | Veneral disease | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Congenital Abnormalities | <input type="checkbox"/> No <input type="checkbox"/> Yes | Other serious diseases: | <input type="checkbox"/> No <input type="checkbox"/> Yes | | |

Adult:

- Have you had any serious illness?..... No Yes
 Have you ever been hospitalized or been under medical care for very long?..... No Yes
 If yes, for what reason? _____

Operations:

- Have you had any surgery?..... No Yes
 List _____

Injuries:

- Have you had any broken bones?..... No Yes
 Have you ever been knocked unconscious?..... No Yes
 Have you had head concussions or injuries?..... No Yes

FAMILY HISTORY:	If Living:		If Deceased:		Has any blood relative ever had:				
	Age	Health	Age (at death) & Cause		(if yes, what age & who)	No	Yes	Age	Who
Father					Cancer				
Mother					Tuberculosis				
Brother / Sister					Diabetes				
					Heart Trouble				
					High blood pressure				
Husband / Wife					Stroke				
Son / Daughter					Convulsions				
					Suicide				
					Insanity				
					Bleeding tendency				
					Gout or other arthritis				

SOCIAL HISTORY:

- Circle One:** Single Married Separated Divorced Widowed
 Are you living with your husband or wife?..... No Yes
 Is your sex life satisfactory?..... No Yes
 Do you have dependents at home?..... No Yes
 Alcoholic Beverages: Never Rarely Moderately Daily Ever?..... No Yes
 Tobacco: Cigarettes _____ Packs a day Don't Smoke Ever smoked?..... No Yes
 Are you employed? Full Time Part Time What is your job? _____
 Are you exposed to fumes, dusts or solvents? _____

Education:

- Grade School _____ (years) High School _____ (years) College _____ (years) Postgraduate _____ (years)
 How much time have you lost from work because of your health during the past?
 Six Months _____ One Year _____ Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

- Recent weight change?..... No Yes
 Have you been in good general health most of your life?..... No Yes

Skin:

- Skin Disease..... No Yes
 Jaundice..... No Yes
 Hives, eczema or rash..... No Yes
 Frequent infection or boils... No Yes
 Abnormal pigmentation..... No Yes

Head-Eyes-Ears-Nose-Throat

- Eye disease or injury..... No Yes
 Do you wear glasses?..... No Yes
 Double vision..... No Yes
 Headaches..... No Yes
 Glaucoma..... No Yes
 Itching eyes or nose..... No Yes
 Sneezing or runny nose..... No Yes
 Nosebleeds..... No Yes
 Chronic sinus trouble..... No Yes
 Ear disease..... No Yes
 Impaired hearing..... No Yes
 Dizziness or transient episodes of unconsciousness..... No Yes



HEALTH QUESTIONNAIRE

PT. NAME: _____

DOB: _____ FC: _____

MR#: _____ CHB: _____

PHYSICIAN: _____ PHY. #: _____

DATE: _____ LOC: _____

Neck:

Stiffness No Yes

Thyroid trouble No Yes

Enlarged glands No Yes

Respiratory:

URI (cold) now No Yes

Spitting up blood No Yes

Chronic or frequent cough ... No Yes

Asthma or Wheezing No Yes

Difficulty breathing No Yes

Any trouble with lungs No Yes

Pleurisy or Pneumonia No Yes

Cardiovascular:

Chest pain or angina pectoris No Yes

Difficulty walking two blocks . . . No Yes

Heart trouble or heart attacks No Yes

High blood pressure No Yes

Swelling of hands, fee or ankles ... No Yes

Awakening in the night smothering. . No Yes

Heart murmur No Yes

Shortness of breath with walking or lying down No Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal) . . No Yes

Vomiting blood or food No Yes

Gallbladder disease No Yes

Liver trouble No Yes

Hepatitis No Yes

Painful bowel movement No Yes

Bleeding with bowel movements ... No Yes

Black stools No Yes

Hemorrhoids or piles No Yes

Recent change in bowel habits No Yes

Frequent diarrhea No Yes

Heartburn or indigestion No Yes

Cramping or pain in the abdomen . . No Yes

Does food stick in throat. No Yes

Genitourinary

Loss of urine No Yes

Frequent urination No Yes

Night time urinating No Yes

Burning or painful urination . . No Yes

Blood in urine No Yes

Kidney trouble No Yes

Kidney stones No Yes

Bright's Disease No Yes

Gynecological

Age periods started _____ How long do periods last? _____ Days Number of pregnancies _____ Number of miscarriages _____

Date of last cancer smear and results _____

Frequency of periods, every _____ days. Any pain with your periods... No Yes Number of children _____ Ages _____

Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose veins No Yes

Weakness of muscles or joints . . . No Yes

Any difficulty in walking No Yes

Any pain in calves or buttocks on walking relieved by rest No Yes

Neuro-Psychiatric:

Have you ever had psychiatric care? . No Yes

Convulsions No Yes

Paralysis No Yes

Have you been advised to see a psychiatrist? No Yes

Do you ever have, or have had, fainting spells? No Yes

Hematologic:

Are you slow to heal after cuts No Yes

Blood disease No Yes

Anemia No Yes

Have you had abnormal bruising or bleeding? No Yes

Phlebitis No Yes

Have you had difficulty with bleeding excessively after tooth extraction or surgery? . . No Yes

Allergic:

Any allergies, including medication No Yes

Endocrine

Thyroid disease No Yes

Hormone therapy No Yes

Any change in hat or glove size ... No Yes

Any change in hair growth ... No Yes

Have you become colder than before or skin become dryer No Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

Check One

What Drug or Food?

- Penicillin or other antibiotics No Yes Don't know
- Morphine, Codeine, Demerol or other narcotics No Yes Don't know
- Novocain or other anesthetics No Yes Don't know
- Aspirin, empirin or other paid remedies No Yes Don't know
- Sulfa drugs No Yes Don't know
- Tetanus antitoxin or other serums. No Yes Don't know
- Adhesive tape No Yes Don't know
- Iodine or merthiolate No Yes Don't know
- Any other drug or medication No Yes Don't know
- Any foods, such as egg, milk or chocolate. No Yes Don't know

2. Drugs Recently Taken: Within the past six months has patient taken:

- Cortisone No Yes Don't know
- ACTH No Yes Don't know
- Anticoagulants No Yes Don't know
- Tranquilizers No Yes Don't know
- Hypotensives (high blood pressure medicines) No Yes Don't know
- Has the patient ever received treatment for: Asthma, rheumatism or rheumatic fever? . . No Yes Don't know
- Aspirin No Yes Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor

Date

Signature of Patient

Form PF-2000

Acknowledgement of Receipt of Notice of Privacy Practices

The Practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices which is also posted in the reception area of this office. I may receive a copy of an amended notice upon request at subsequent visits. This notice can also be found and downloaded from www.prohealthpartners.com

Name of patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if patient is a minor or an adult who is unable to sign this form)

Relationship of Representative

Documentation of Attempt to Obtain Acknowledgement of Receipt of Privacy Practices

An attempt was made to obtain an acknowledgement of the Notice of Privacy Practices on

_____. The acknowledgement was not obtained because:
Date

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other _____

Signature: _____

Name of the patient: _____

Name of Staff Member: _____

Date: _____

Authorization Form for Release of Confidential Health Information

I hereby authorize _____ Telephone _____
(Name of Physician)

Address _____ City _____ State _____ Zip _____

To (choose one): () Release to () Obtain from

Naples Medical Group

(Name of Healthcare Facility or Physician)

5865 E. Naples Plaza, Long Beach, CA 90803

(Street Address, City, State, and Zip Code)

Telephone **(562) 434-4481** Fax **(562) 434-5713**

The following information authorized for release:

- () The entire medical record
() Other: _____

This authorization shall remain in effect from the date signed below until _____

This information is being requested for the following purpose (mandatory in order to process request):

- () Moved () Change of Insurance () Second Opinion () Personal
() Primary Care Physician Update () Transfer of Care
() Other: _____

- I understand that I have the right to inspect or copy the protected health information that I have authorized to be disclosed.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.
- I understand that I may revoke this authorization at any time by giving written notice to the physician's office of my desire to do so. I also understand that I will not be able to revoke this authorization in cases when the physician has already relied upon the use or disclose my personal health information.
- I understand that I may refuse to sign this authorization, and that you will not condition treatment on me, with the exception of:
 1. When the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party or
 2. For research-related treatment in which case you may refuse to provide the research-related treatment.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Relationship to Patient (if signed by personal representative): _____

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated
by the Medical Board of California.

To check up on a license or
to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

Date

Patient's Name (Type or Print)

Patient's Signature

Date

Patient Representative's Name
and Relationship (Type or Print)

Patient's Representative's
Signature

Original to be maintained in patient's medical records.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ (Date) By: _____ (Date)
Physician's or Authorized Representative's Signature Patient's or Patient Representative's Signature (Date)
Print Patient's Name

Print or Stamp Name of Physician, Medical Group or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.