ARGYLL MEDICAL GROUP

Welcome New Argyll Patients

Welcome to Argyll Medical Group where our motto is, ***"Upgrade to Personal Service Family Medicine".***

Your new patient packet has several forms that will assist us in providing you the best possible healthcare service.

1) Adult Medical History Form: We first ask patients to provide us with detailed health information that is important for the first visit and ongoing healthcare as a long term Argyll patient.

2) Patient Information/ Responsible Party Information: We ask patients to provide use with their specific personal information in order to register them as an Argyll patient and for administration purposes.

3) Assignment of Insurance Benefits and Collection Policy: We are happy to work with patients to bill their insurance. This form authorizes Argyll to bill the insurance on behalf of the patient. It also provides important information to clarify the patient's responsibility for any charges not covered by their insurance.

4) Authorization to Release Medical Records: Argyll will take care of obtaining your medical records with this form.

5) Authorization for Use and Disclosure of Protected Health Information: Patients can use this form to transfer their records outside the group. You can also authorize your staff to discuss your health information with relatives etc.

6) Internet Communication Consent: Used carefully, e-mail communication can be a worthwhile option for patients to get the most out of Personal Service Family Medicine.

7) Patient Financial Policy Letter: Argyll asks patients to work with us to remain the healthcare provider of choice in the area by fairly paying for services rendered. We find establishing a clear financial agreement with patients from the beginning helps to avoid misunderstandings.

Other resources new patients should be aware of:

Finance Department: We make an effort to be there for you if you have temporary difficulty meeting your financial responsibility for the health services you and your family need. The Finance Department can also answer questions about your bill. New patients should inquire about our Convenience Payment Options.

Group Manager: Argyll is known for our policy of openness with our patients and our "customer service" philosophy for healthcare. Patients are encouraged to bring up concerns or praise regarding the service they receive. Patients may meet with the manager in person, via e-mail, or complete a quality survey.

Personal Service: Argyll is sincere in our commitment to delivering ***"Personal Service Family Medicine"***. Our staff are particularly approachable and reachable during business hours. Make sure to take your Argyll physician's card for the direct number to your office and discuss with the staff the best way to get your concerns addressed in a timely manner. Patients might also consider taking our Business Information and Directory card to their pharmacy etc to ensure administration between our offices is handled with the convenience and efficiency Argyll patients become accustomed to.

Each practice independently owned. Management services provided by Argyll Medical Group LLC

Attention Staff: Please provide this information to new Argyll patients along with their New Patient Packet

ARGYLL MEDICAL GROUP

Adult Medical History Form

Please print your name:____
What concern do you wish me to address today?______________________________

There are many questions below that I ask you to answer. They may help me better understand how to treat the concern that brought you here today. They might also remind you of other issues you'd like addressed. Depending on their nature, some of these issues may be covered today and some others may require a separate office visit so I can give them the time and attention they deserve.

Please list all medicines you are currently taking, including doses and times. You may request additional paper if needed.

____

____

____

____

Please list any allergies or bad reactions you have to medications: ________________________

Do you smoke now or have you smoked regularly in the past? **N Y** How much? ____________________

Do you drink alcohol? **N Y** How much? ____

Do you follow a special diet? **N Y** What? ____

Are you sexually active? **N Y** What type of contraceptive method do you use? ____________________
Are there specific health problems that are common in your family?

____

Please list when you've last had the following items:

Everyone:
- Tetanus shot: __________
- Cholesterol check: _________
- Fasting blood sugar check: _________
- (50 and up) Colon cancer screening: _________
- (65 and up) Pneumonia shot _________

Women:
- Pap Smear
- (age 40 and up) Mammogram
- (age 65 and up) Bone Mineral Density scan

Past Medical History: **Please *circle the specific item* for *each* yes answer**

Y N Any major illnesses or injury in the last 5 years
Y N Head/Brain injuries, disorders or illnesses
Y N Seizures, epilepsy
Y N Eye disorders or impaired vision (except glasses or contacts)
Y N Ear disorders, loss of hearing or balance
Y N Heart disease or heart attack
Y N Heart surgery (valve replacement/ bypass, angio plasty, pacemaker)
Y N High blood pressure
Y N High cholesterol
Y N Muscular disease
Y N Lung disease, emphysema, asthma, chronic bronchitis
Y N Kidney disease, dialysis
Y N Liver disease
Y N Digestive problems
Y N Diabetes or elevated blood sugar
Y N Nervous or psychiatric disorders
Y N Sleep disorders
Y N Stroke or paralysis
Y N Missing or impaired hand, arm, foot, leg, finger, toe
Y N Spinal injury or osteoporosis
Y N Chronic low back pain
Y N Regular, frequent alcohol use
Y N Narcotic or habit forming drug use
Y N Other conditions not listed above (list below)

For Women:
Y N History of abnormal breast or cervical exam findings

____

Have you ever had any surgeries? N Y Please list below:

____

____

Review of symptoms that have may have troubled you over the *past month*:

Please circle the Y or N for each question —and— Please *circle the specific item* for *each* yes answer

Y N Unexplained weight change, fevers, chills or night sweats

Y N Vision changes, eye pain, redness, irritation, Light bothering eyes, double vision, blurred vision

Y N Hearing loss, nasal congestion, snoring

Y N Chest pain, feeling unusual heartbeats, Fainting, needing to sleep on more pillows to breath easily.

Y N Shortness of breath at rest or increasing with exercise, chronic cough

Y N Nausea, vomiting, diarrhea, changes in stool.

Y N Urinary urgency, increased frequency or pain. Frequent nighttime urination. Problems with sexual function.

Y N Any muscular weakness or pain?

Y N Rashes or itching, non-healing sores, easy bruising or bleeding tendencies.

Y N Frequent headaches, loss of conscious ness, numbness, weakness.

Y N Excessive thirst, feeling unusually hot, cold or tired?

Y N Lymph node swelling or pain

Y N Problems with depression or anxiety

Y N Problems with allergy?

For Women:

When was your last period? ____________________

Y N Heavy, painful or irregular periods

Y N Vaginal dryness, discharge or irritation

Y N Breast swelling, lumps, pain, nipple discharge

Y N Do you think you may be pregnant?

Y N Are you breast feeding?

Always tell your doctor at each exam if you think you may be pregnant or are breastfeeding.

Other conditions not listed above (describe below)

____

____

____

Signed: ______________________________ **Date:** __________

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Attention Staff: File this document as **PATIENT DOCS>PATIENT MEDICAL HISTORY**

ARGYLL MEDICAL GROUP

PATIENT INFORMATION/ RESPONSIBLE PARTY INFORMATION

Patient Name____Date of Birth:______/____/________

Maiden Name:____

SS#______-______-______ Gender: M F

Marital status: (circle one) Single Married Widowed Divorced/Separated

Address_____________________________City:_________ State:______ ZIP:________

Mailing Address (if different from home address):
Address_____________________________City:_________ State:______ ZIP:________

E-mail address:____

Phone Number (Home)__________________ Phone Number (Cell)______________________

Driver's License #:__________________ State:_____________

Please Check:
____ Full Time Student ____ Part Time Student ____ Retired

Employer____________________Occupation: ______________________________
Business phone ( )_______________

SPOUSE /PARTNER or PARENT/GUARDIAN (circle one)

Name____Date of Birth:______/____/________

Gender: M F

Address_____________________________City:_________ State:______ ZIP:________

Mailing Address (if different from home address):
Address_____________________________City:_________ State:______ ZIP:________

E-mail address:____

Phone Number (Home)__________________ Phone Number (Cell)______________________

Driver's License #:__________________ State:_____________

Please Check:
____ Full Time Student ____ Part Time Student ____ Retired

Employer____________________Occupation: ______________________________
Business phone ( )_______________

In Case of Emergency:
I give permission to contact Name:________________________________ and discuss aspects of my medical condition as needed for ongoing care.
Phone number( )_____________________________
This person is my (friend, family member etc):__________________________

Signed:___________________________________ Date:____________________

ARGYLL MEDICAL GROUP

ASSIGNMENT OF INSURANCE BENEFITS AND COLLECTION POLICY

Primary Insurance:_______________________ Secondary Insurance:_______________________

Insured Name:___________________________ Insured Name:______________________________

Insured DOB:____________________________ Insured DOB:_______________________________

I understand that I am ultimately responsible to pay fees charged for services rendered by Argyll Medical Group. Although my insurance will be billed as a courtesy to me I will still be responsible for services they decline payment for, or do not cover. In order to allow billing of my insurance I hereby irrevocably assign and transfer all rights, title, and interest in the benefits payable for services rendered by Argyll Medical Group, provided in the above mentioned policy (ies) of insurances, but shall not be construed to be an obligation for them to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standings to make claim or sue the insurance company for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize all benefits due under said policy (ies) and by reason of services rendered therein. I will pay Argyll Medical Group for all charges incurred or, alternatively, for all charges in excess of subs actually paid pursuant to said policy (ies). If an outside collection agency is required to collect any outstanding services (90 days or older) by Argyll Medical Group, a finance charge of $12.00 or greater will be applied to the balance and any extra cost incurred to collect the outstanding balance will be the responsibility of the patient/guarantor. There is an additional $3.00 charge per statement mailed to you after 61 days. **Patient / Guarantor is aware that $15.00 to $40.00 will be charged to the you in the event that an appointment is cancelled or missed within 24 hours of its scheduled time.**

Argyll Medical Group are dedicated to maintaining the privacy of your individually identifiable health information (also called Protected Health Information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. You may still obtain copies of your records to take or be sent to another health care provider for a $20.00 charge. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that he have in effect at that time. I give Argyll Medical Group permission to, as a courtesy to me, to from time to time contact myself or leave a message at my home to confirm appointment times or notify me of the need to discuss test results or other medical issues.

Patient Name:___________________________Birth Date:___________________

Signed: ___________________________________ /__________________________

Signature of patient or legal guardian — Relationship to patient

Date: ______________________

Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

PLEASE PRESENT YOUR INSURANCE CARDS WITH THIS COMPLETED FORM SO THAT THEY MAY BE COPIED AND PLACED IN YOUR CHART.

ARGYLL MEDICAL GROUP

Argyll Medical Group
100 independence Circle
Chico, CA 95973
Phone: (530) 899-0295
Fax: (530) 899-0142

Authorization to Release Medical Information FROM another person or party TO Argyll Medical Group

This authorization to release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Section 56 et seq. of the California Civil Code.

I hereby request and authorize:

FROM_____________________________________PHONE______________
(Name of physician, health care practitioner, hospital, clinic or medical related facility)

ADDRESS____

CITY, STATE, ZIP____

To discuss and or release all information, including medical records, x-rays, history and findings and prognosis pertaining to the medical condition of , services rendered, or treatment given to:

______________________________________ ______________________________________
(Patient's Name) (Birth Date)

______________________________________ ______________________________________
(Parent or Power of Attorney for Health Care) (Social Security Number)

As specified please release to Argyll Medical Group.

Limitations on discussion and release. if any:

____

____

____

____

____

Patient Signature (Authorized Signature)_______________________________________ Date:________________

ARGYLL MEDICAL GROUP

Argyll Medical Group
100 independence Circle
Chico, CA 95973
Phone: (530) 899-0295
Fax: (530) 899-0142

Patient Authorization for Use and Disclosure of Protected Health Information FROM Argyll Medical Group TO another person or party

TO_________________________________ PHONE_____________

FAX:____

ADDRES____

CITY, STATE, ZIP____

We are often asked to divulge information about patient status/ care from well-meaning loved ones. We would be happy to do so but require the specific permission of all consenting adults for this. If you wish to allow information about your medical care to be shared with anyone, please indicate which family members or friends you would allow us to speak to.

Name:____________________Relation:__________ Name:____________________Relation:__________

Name:____________________Relation:__________ Name:____________________Relation:__________

Name:____________________Relation:__________ Name:____________________Relation:__________

By signing this form I authorize Argyll Medical Group to use and/or disclose any and or all types of individually identifiable health information about me (Protected Health Information), or I may specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level etc except as specified below:

____

____

The information will be used or disclosed for purposes at the discretion of the requesting party, or for other purposes if specified below:

____

____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

I do not have to sign this authorization in order to receive treatment Argyll Medical Group. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Group Manager in writing at:
Argyll Medical Group, Group Manager, 100 Independence Circle, Chico CA 95973. (530) 899-0295
info@argyllmedical.com

____

Signature of patient or legal guardian   Date   Relationship to patient

____

Print name of patient , and of legal guardian if used   Print birth date of patient

Each practice independently owned. Management services provided by Argyll Medical Group LLC

Attention Staff: File this document as **LEGAL>MEDICAL RECORD RELEASE REQUEST**

ARGYLL MEDICAL GROUP

Internet Communication Consent

As an additional service to you, we have the ability to occasionally communicate with you over the internet. This may be in the form of test results which we may send you and/or generally short email messages.

We try to go beyond the services of other clinics by engaging in internet communication with our patients. Unfortunately, due to the time required, we are unable to use email for extended and complex answers to questions about your results. It is important that you understand your test results. If you need further explanation, please call our office. We'd be glad to schedule an appointment to discuss your questions in depth.

Communication via the internet is only as secure as the internet itself and your own email account. As this involves your protected health information it is important to think carefully about the general risks, benefits and limitations of doing this. We have no way of knowing who else might be able to read your email. It is up to you to give us only an email address that you feel is appropriately secure for your needs. We will assume that it is appropriate for us to send email to the address that you give us until you notify us in writing that this is not the case.

Email you send may not always reach us. Be sure to check your email filters if you believe we have sent email that has not reached you. The title from our record system generally states "Confidential email from your doctor" but this may vary. The email will show that it is from the group or your doctor's name @alteer.com. If have not received an expected communication from our office within a week and have no appointment scheduled within the upcoming month, call and check to see if there is a problem.

Your signature gives us permission to send any result and or commentary about your health to the email address you provide below. Your signature also means that you understand that we will expect you to have received the results after we have sent them unless you call us and tell us otherwise. Without your signature on this form we will not send you any information via email.

I have read the above and after careful consideration agree to internet communication with the offices of Argyll Medical Group.

Printed Name___________________________________

Signature: ____ Date: ___________

Email address:_________________________________

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Attention Staff: File this document as **LEGAL>E-MAIL CONSENT** (NOT PATIENT DOCS>E-MAIL)

ARGYLL MEDICAL GROUP

Patient Financial Responsibility

(Policies effective 5-1-06)

Thank you for choosing Argyll Medical Group, Chico for your healthcare.

We wish to work with you to help preserve your health and treat any illness that may occur.

We have the following financial policies which apply to all patients and are a condition of receiving services from Argyll Medical Group physicians. Keeping with our policy of openness our terms of service are presented simply here.

Please note each physician practice is independently owned but all receive management services from Argyll Medical Group LLC including billing. Questions about bills from Quest Laboratories should be directed to them.

- Co-payments and Deductibles are due at the time of service, other than for Medicare and Workers Compensation patients.
- We will bill your insurance. It is your responsibility to make sure your doctor's office is informed of any insurance changes, change of address, telephone etc.
- If your insurance does not pay within 60 days for any reason (other than Medicare lack of medical necessity) the full cost of services is your responsibility.
- Bills are due on presentation. For your convenience we do accept checks, cash and all major credit cards + debit cards. Payment can be made in the office, by mail or by calling 530 899 9038.
- Interest accrues at 1.5% of the outstanding balance monthly on bills unpaid after 30 days of initial presentation. At 90 days bills are sent to a collection agency and may be noted on your credit score. Patients with bills in collection are likely to be asked to seek care elsewhere.
- If you have financial difficulties please contact the billing office at 530 899 9038 or billing@argyllmedical.com to establish an acceptable payment plan. Interest will be charged at 1.5% of the unpaid balance per month.
- Charges do apply if you do not show for an appointment or cancel at short notice and also for "non visit care". See our website www.argyllmedical.com for details.
- While staff will try to assist with billing problems, ultimately dealing with your insurer and understanding your coverage is your own responsibility. We will inform new patients whether their insurance is "in network" – if not it is your responsibility to check what your "out of network" coverage may be. We participate with most insurers and Medicare but not Medi-Cal.

Roy L Bishop MD
CEO Argyll Medical Group LLC

Patient Name_________________________ Date _________________________

Signature______________________

Attention Staff: File this document as **PATIENT DOCS>FINANCIAL RESPONSIBILITY FORM**