

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/ Responsibility Party Information:** We ask patients to provide us with their specific personal information to register them as an Argyll patient and for administration purposes.
- **3. Authorization to Release Medical Records:** Argyll will take care of obtaining your medical records with this form.
- 4. Patient Acknowledgement of Privacy Practices/ Limited Authorization: This informs patients on Argyll's privacy practices.
- **5. Patient Portal Consent:** Allows Argyll to enable your Patient Portal where you can access your Personal Health Information and communicate securely with your provider.
- **6. 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.
- 7. Patient Financial Policy Letter: Argyll asks patients to work with us to remain the health care 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 avoid misunderstandings.

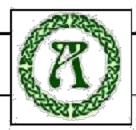
Other resources new patients should be aware of:

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 is 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.

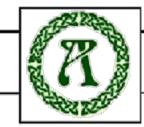
Each practice independently owned. Management services provided by Argyll Medical Group LLC



ADULT MEDICAL HISTORY FORM

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.

| riease print your name. |
|--|
| What concern do you wish me to address today? |
| 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: |
| Please list when you've last had the following items: |
| Tetanus shot: |
| Cholesterol check: |
| Fasting and blood sugar check: |
| (50 and up) Colon cancer screening: |
| (65 and up) Pneumonia Shot: |
| |



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,
 Angioplasty, pacemaker)
- Y N High blood pressure
- Y N Muscular disease
- Y N Lung disease, emphysema, asthma, chronic bronchitis
- Y N Kidney disease, dialysis
- Y N Liver Disease
- Y N Bone Mineral Density scan When?
- Y N History of abnormal breast or cervical exam
- Y N Heavy, painful or irregular periods

- 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:

When was your last period?

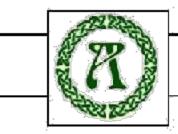
Pap smear?

Mammogram?

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

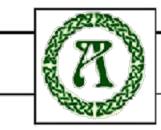
Surgical History:

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



Hospital History: Have you been hospitalized in

the past? Y N



Family History:

Are there specific health problems that are common in your family? Y N

| Social F | listory: |
|----------|----------|
|----------|----------|

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

Do you drink alcohol? Y N How much?

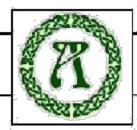
Review of symptoms that have may have troubled you over the past month:

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

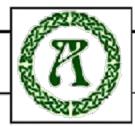
- Y N Frequent nighttime urination, problem with sexual function
- Y N Rashes or itching, non-healing sores, easy bruising or bleeding tendencies
- Y N Excessive thirst, feeling unusually hot, cold or tired
- Y N Lymph node swelling or pain
- **Y N** Frequent headaches, loss of consciousness, numbness, weakness
- Y N Problems with depression or anxiety
- Y N Problems with allergy
- Y N Other conditions not listed above(describe below)

| Signature: | Date: |
|------------|-------|
| 9 | |



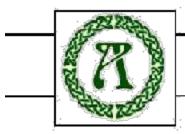
PATIENT INFORMATION/RESPONSIBILITY PARTY INFORMATION

| Patient Name: | | | |
|--|----------------------------|--------------|--------|
| Date of Birth: | | | |
| Maiden Name: | | | |
| SS#: | | | |
| Gender: M F | | | |
| Marital status (<i>CIRCLE</i> one): Singl | e Married Windowed | Divorced/Sep | arated |
| Address: | City: | State: | Zip: |
| Mailing Address (if different from Address: | n home address): City: | State: | Zip: |
| Phone Number: (home) Pho | ne Number: (cell) Driver's | s License #: | |
| Please Check:Full Time Stude | ent _Part Time Student _Re | etired | |
| Employer: | Occupation: | | |
| Business Phone: | | | |
| | | | |



SPOUSE/PARTNER or PARENT/GUARDIAN (circle one)

| Name: | | | |
|---|-----------------|----------------|--|
| Date of Birth: | | | |
| Gender: M F | | | |
| Address: | City: | State: | Zip: |
| Email Address: | | | |
| Phone Number: (home) | Phone | Number: (cell) | |
| Driver's License #: | | | |
| Please Check:Full Time Student | Part Time Stu | dentRetire | ed |
| Employer: | Occupatio | n: | |
| Business Phone: | | | |
| In Case of Emergency: I give permission to contact the folloongoing care. | owing person to | discuss aspect | ts of my medical condition as needed for |
| Name: | | | |
| Relationship: | | | |
| Phone Number: | | | |
| Signature: | | | Date: |



Patient Name:

ARGYLL MEDICAL GROUP

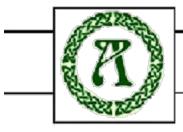
CONSENT
FOR
RELEASE OF
MEDICAL

RECORDS USE

AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Date of Birth:

| 1. Please send contain): | a copy of my records (inclu | ding information fror | m other health-care providers that it may |
|---|---|--|---|
| Doctor's Name: | | Your Name: | |
| Doctor's Address | 100 Independence Circle | Your Address: | |
| City/State/Zip: | Chico, CA. 95973 | City/State/Zip: | |
| Doctor's Phone | 530-899-0295 | Your Phone: | |
| Doctor's Fax | 530-899-0142 | | |
| it, and do hereby ag indemnify this Healt under this Consent. | ree to its terms. A copy of this sigr hcare Facility, its employees and ag | ed, dated Consent shall be a ents for any and all liability (i care Facility to use and disc | been given an opportunity to ask questions about it, understan as effective as the original. I release, hold harmless and agree t including but not limited to negligence) arising out of or occurrin lose verbally, by mail, fax, encrypted or unencrypted email, the |
| | | | те арргорпасе). |
| | ding HIV test results) and sexual erapy records / this serves as my | | Alcohol and substance abuse diagnosis and treatment |
| records Psychothe | | signature release under l | Alcohol and substance abuse diagnosis and treatment |



OFFICE POLICY ON MEDICATION REFILLS

Local Pharmacy

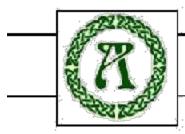
Please call your local pharmacy with all refills. They will contact our office with refill information. Please allow up **72 hours** for processing refill request. Please request refills 3-5 days before your last dose. This is the most efficient way to adequately document in your chart medications being prescribed and refilled. Controlled substances need to be on a secure prescription, they can be requested from the office and picked up. Please be aware that ALL physicians have **72 hours** to complete any refill. This means do not wait till you have taken your last pill. All pharmacies including mail order pharmacy are aware of our policies. If you are requesting multiple prescriptions and clarification is required to fulfill your needs an office visit will be requested by the physician.

Mail Away Pharmacies

If you choose to send your prescription to an out of town pharmacy, you will be responsible for mailing new prescriptions. We do not have the resources to confirm if they received your prescription, if your mail away pharmacy requests a 90-day supply, it is still at the physician's discretion. If he or she feels a 90-day supply is at your best interest at that time. Example: If you are on a medication for your thyroid the physician might want to review labs before giving a new prescription in case there is a dosage change.

Additionally, if the staff or physicians spend a great deal of time with prior authorizations or clarifications when dealing with your prescriptions an administrative fee will be applied. Your cooperation is appreciated. Hopefully this will help clarify all questions regarding prescription refills.

| | Initials: |
|---------------------|-----------|
| | |
| Local Pharmacy: | |
| Address /location: | |
| Mail Away Pharmacy: | |
| Phone: | |
| Signature: | Date: |



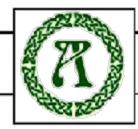
MISSED APPOINTMENT FEE AND CANCELLATION FEE

This is a notice that we reserve the right to charge for missed appointments or cancellations with 24 working hours of the appointment time. Our missed appointment fee is \$20.00 for a 15-minute appointment and \$40.00 for a 30-minute appointment.

Missed appointments use up valuable time that could be used to better accommodate another patient who needs to be seen. We do understand that life does happen and that sometimes a last-minute cancellation is inevitable, however, reoccurring cancellations or no shows are an inconvenience to our patients and staff.

We greatly thank you for your understanding and appreciate your future consideration in any cancellations that you may require.

| Print name: | | |
|-------------|-------|--|
| | | |
| | | |
| Signature: | Date: | |

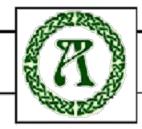


PATIENT FINANCIAL RESPONSIBILITY

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 in dependently owned abut all receive management services from Argyll Medical Group LLC including billing. Questions about bills from Quest Laboratories, Valley Clinical Lab or any outside facilities should be directed to them.

| | Co-payments and Deductibles are due at the time of service, other the Workers Compensation patients | nan for Medicare and |
|-------|---|-----------------------------------|
| | | r doctor's office is informed of |
| | ☐ If your insurance does not pay within 60 days for any reason (other t medical necessity) the full cost of service s is your responsibility. | han Medicare lack of |
| | ☐ Bills are due on presentation. For your convenience we do accept ch credit/debit cards. Payments ca n be made in the office, by mail or b | , |
| | ☐ Interest accrues at 1.5% of the outstanding balance monthly on bills presentation. At 90 days bills are sent to a collection agency and masscore. Patients with bills in collection are likely to be asked to seek calls. | y be noted on your credit |
| | ☐ If you have financial difficulties please contact the billing offices at 55 billing@argyllmedical.com to establish an acceptable payment plan. of the unpaid balance per month. | |
| | ☐ Charges do apply if you do not show for an appointment or cancel at visit care". See our website www.argyllmedical.com for details. | short notice and also for "non |
| | ☐ While staff will try to assist with billing problems, ultimately dealing understanding your coverage is your own responsibility to check who may be. We participate with most insurers and Medicare but not Med | at your "out of network" coverage |
| Ro | Roy L Bishop MD | |
| CI | CEO Argyll Medical Group LLC | |
| Signa | nature: Da | ate: |
| | | |



Primary Insurance:

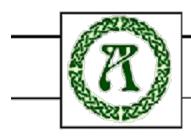
ARGYLL MEDICAL GROUP

Insured DOB:

ASSIGNMENT OF INSURANCE BENEFITS AND COLLECTION P OLICY

Insured Name:

| Secondary Insurance: | Insured Name: | Insured DOB: |
|--|--|--|
| or do no cover. In order to allow billing of rinterest in the benefits payable for services policy(ies) of insurances, but shall not be company for benefits individually should company or benefits individually should company or benefits individually should company for benefits indiv | ourtesy to me I will still be responding y insurance I hereby irrevocables rendered by Argyll Medical Group onstrued to be an obligation for the ansfer shall not take away my state overage be denied by any insurant fervice rendered therein. I will pexcess of substantially paid pursuant outstanding services (90 days or to the balance and any extra cost arantor. There is an additional \$3 \$ 15.00 to \$40.00 will be charged. | nsible for services they decline payment for, y assign and transfer all rights, title and up, provided in the above-mentioned them to pursue any such right of recovery. Indings to make claim or sue the insurance are carrier(s). I hereby authorize all benefits pay Argyll Medical Group for all charges uant to said policy(ies). If an outside |
| maintain in our practice concerning your P Privacy Practices that we have in effect at t | I). In conduction our business, we are required by law to maintain pies of your records to take or be vide you with this notice of our let HI. By federal and state law, we shat time. | e will create records regarding you and the a the confidentiality of health information sent to another care provider for a \$20.00 egal duties and the privacy practices that we must follow the terms of the Notice of |
| Signature: | Birth | n Date: |

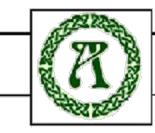


PATIENT ACKNOWLEDGEMENT OF RECEIPT OF A NOTICE AND ACCESS OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we <u>may not be allowed</u> to process your insurance claims.

| Date: | |
|--|---|
| The undersigned acknowledg healthcare facility. A copy of to MY SIGNATURE WILL ALSO SI | es access to a copy of the currently effective Notice of Privacy Practices for this this signed, dated document shall be as effective as the original. ERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE. |
| | |
| name of Patient Please | <i>sign</i> for Patient / Guardian of Patient |
| | TIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: randparents and any care takers who can have access to this patient's records): |
| Name: | Relationship: |
| Name: | Relationship: |
| Name: | Relationship: |
| I AUTHORIZE CONTACT FROM INFORMATION VIA: | THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING |
| Cell Phone Confirmation | Text Message to my Cell Phone |
| Home Phone Confirmation | Any of the Above |
| Work Phone Confirmation | |
| I AUTHORIZE INFORMATION | ABOUT MY HEALTH BE CONVEYED VIA: |
| Cell Phone Confirmation Home | , |
| Phone Confirmation Work Phone Confirmation | Any of the Above |
| work Priorie Confirmation | |

I WISH TO ENABLE MY <u>PATIENT PORTAL ACCOUNT</u>. Please email my login and password to (enter your email address):



Argyll Medical Group providers are not contracted with Medi-Cal.

As current regulations do not allow us to charge patients who have Medi-Cal as a secondary to Medicare.

If you have Medicare and no secondary insurance, please sign this form to confirm that you **do not have Medi-Cal** and that you will notify us if you do sign up for Medi-Cal.

| This is to certify that I (patient name) | _do not |
|---|---------|
| have Medi-Cal as my secondary health insurance. | |
| | |
| | |
| | |

Signature/Date