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/ 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.

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:

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:_____

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 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?_____

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 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

Y N Vaginal dryness or discharge

Y N Breast pain or lumps

****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 History:

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 Low back or joint pain

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 Frequent heartburn

Y N Problem with memory

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

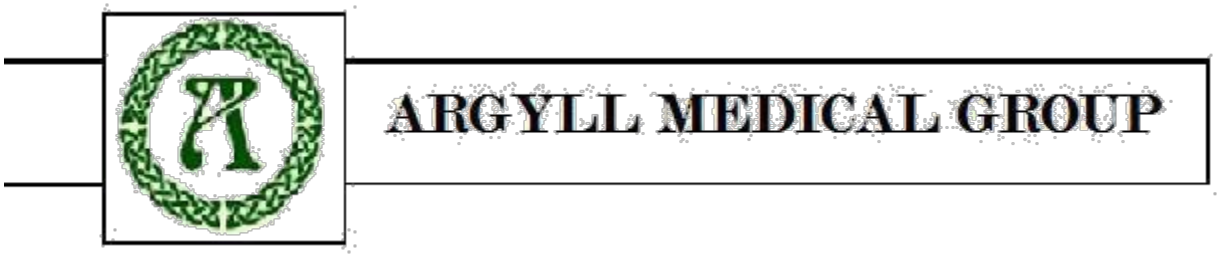
Y N Frequent headaches, loss of consciousness, numbness, weakness

Y N Problems with depression or anxiety

Y N Problems with allergy

Y N Other conditions not listed above(describe below)

Signature: _____ Date: _____



PATIENT INFORMATION/RESPONSIBILITY PARTY INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Maiden Name: _____

SS# ___ - ___ - ___ Gender: M F

Marital status: ***CIRCLE*** one Single Married Windowed Divorced/Separated

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different from home address)

Address: _____ City: _____ State: _____ Zip: _____

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: _____

Email 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: _____ Relationship: _____

Signature: _____ Date: _____

ARGYLL MEDICAL GROUP

CONSENT FOR RELEASE OF MEDICAL RECORDS USE

AND DISCLOSURE OF PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Patient Name: _____Date of Birth:_____/_____/_____

COMPLETE AS APPLICABLE:

1. Please send a copy of my records (including information from other health-care providers that it may contain):

Your Doctor's Name:		**Receiving Doctor:**	
Doctors Address:	100 Independence Circle	**Doctor's Address**:	
City/State/Zip:	Chico, CA. 95973	**City/State/Zip:**	
Doctor's Phone:	530-899-0295	**Your Phone:**	
Doctor's Fax:	530-899-0142		

I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law. I acknowledge that this Healthcare Facility, in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical records to the party listed above. I have reviewed the NOPP of this healthcare facility and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

HIV records (including HIV test results) and sexually transmissible diseases Alcohol and substance abuse diagnosis and treatment records Psychotherapy records / this serves as my signature release under Federal law

Other / Specify: _____

Signature: _____ Date: _____

ARGYLL MEDICAL GROUP

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:_____ Fax: _____

Signature: _____ Date: _____

ARGYLL MEDICAL GROUP

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: _____

ARGYLL MEDICAL GROUP

PATI ENT FINANCIAL RESPONSIBILITY

Thank you for choosing Argyll Medical Group for your health care.

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 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 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 ad dress, 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 service s is your responsibility.

Bills are due on presentation. For your convenience we do accept checks, cash and all major credit/debit cards. Payments ca n 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 else-where.

If you have financial difficulties please contact the billing offices at 530-899-903 8 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 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

Signature: _____ Date: _____

ARGYLL MEDICAL GROUP

ASSIGNMENT OF INSURANCE BENEFITS AND COLLECTION P OLICY

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 no cover. In order to allow billing of m y 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 service 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 you in the event that an appointment is cancelled or missed within 24 hours of its scheduled time.**

Argyll Medical Group is dedicated to maintaining the privacy of your individually identifiable health information (also called Protected Health Information, or PHI). In conduction our business, we will create records regarding you and the treatment and services we provide 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 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 P HI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at that time.

Signature: _____ Birth Date: _____ _____

ARGYLL MEDICAL GROUP

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 *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges access to a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

Cell Phone Confirmation
Home Phone Confirmation
Work Phone Confirmation
Text Message to my Cell Phone
Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

Cell Phone Confirmation Home Phone Confirmation
Work Phone Confirmation
Text Message to my Cell Phone
Any of the Above

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

ARGYLL MEDICAL GROUP

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