PACIFIC COAST CARE

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

If minor, name of responsible party/parties: _____

Name you would like to appear on your health records: _____

What are your pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

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

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Preferred Contact Method for Communications will be via the Patient Portal if registered.

Sex: ☐ M ☐ F ☐ Transgender man ☐ Transgender woman ☐ Genderqueer/gender nonconforming, not exclusive

☐ A category not listed here, please specify: _____ ☐ Decline to answer

Do you think of yourself as:

☐ Straight or Heterosexual ☐ Lesbian or gay ☐ Bisexual Queer, pansexual and /or questioning ☐ Don't know

☐ An orientation not listed here, please specify: _____ ☐ Decline to answer

Marital Status: □ S □ M □ D □ W □ Other _____

Education, Language & Demographics:

Primary Language _____ Interpreter Required? ☐ Yes ☐ No

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Highest level of education: ☐ High School ☐ College ☐ Trade School ☐ Other: _____

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

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

Date of Birth _____ Social Security # _____ Relationship to patient: _____

Employer Name: _____ Employer Phone Number: _____

Guarantor Address _____

Phone Number: _____ Email Address: _____

PACIFIC COAST CARE

INSURANCE INFORMATION

Have you recently changed or added to your health insurance?

☐ No, please verify your current information on file. ☐***YES – Give receptionist a copy of your NEW card.***

Primary Insurance Carrier

_____

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 Carrier

_____

Policy Holder Name _____ DOB _____ Social Security #_____

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: _____

_____

PATIENT REFERRAL INFORMATION			
Patient referred by			**Phone #**
Address	**City**	**State**	**Zip**

PREFERRED PHARMACY INFORMATION

In Person Pharmacy Name _____ Address _____

Phone : (_____)_____ Fax : (_____)_____

Mail Order Pharmacy Name:_____

Phone : (_____)_____ Fax : (_____)_____

Note: It is our office policy that no prescription refills will be given after hours or on weekends.

PACIFIC COAST CARE

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 TO THESE CONTACTS, SIMPLY A REQUEST TO CONTACT YOU AND HAVE YOU CALL US.

Emergency Contact Name	Relationship	Phone Number

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

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 receive information	Relationship to Patient	Type of Information			
		All	Medical	Appt Only	Billing Only

Validation Code Word: _____ *(Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)*

Other Required Information

Advance Directive Given: ☐ Yes ☐ No Initials: _____ Adv. Directive Completed & On File: ☐ Yes ☐ No

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

Patient representative/parent name: _____

For patients requiring translation or verbal reading of the document, the reader or translator may document and sign below:

Reader/translator Signature: _____ Date: _____

Reader/translator Printed Name: _____

Relationship to patient: _____

PACIFIC COAST CARE

GENERAL PRACTICE INFORMATION & CONSENT AND OFFICE POLICIES

Welcome to Pacific Coast Care! Thank you for choosing us to be your primary care provider and trusting us with your medical care. Below is some general information regarding our practice as well as some consent forms for providing you with medical care.

We are conveniently located across the street from UCI/Los Alamitos Medical Center and both major laboratories (Labcorp and Quest Diagnostics) are located on the second floor.

Appointments
Appointments are generally scheduled for 20 minutes (40 minutes for senior wellness exams) during regular business hours. Bring your ID and insurance cards to every appointment.

Refills
Medication refills will only be completed during normal business hours, so we encourage you to have your provider refill your medications during your office visits to ensure that you do not run out.

Fees
Patients who fail to show for their appointment, cancel or reschedule within 24 hours of their scheduled appointment time shall be subject to a fee of $50. As a small practice, we appreciate your understanding. Forms not completed at the time of your appointment will be subject to a fee of $25 per page.

CONSENT TO LEAVE VOICEMAIL OR TEXT MESSAGES

I hereby authorize Pacific Coast Care to call or text the following telephone numbers:

Mobile: _____ Work: _____

Home: _____

and leave detailed voice or text messages with the following information (check all that apply):

- ☐ Details about my next appointment (provider name, date/time, and number)
- ☐ Test and other exam results
- ☐ Account payments, balances, or cost estimates

☐ I DECLINE. Please do NOT leave any voice or text messages.

I may refuse to sign this authorization, and it will not affect my ability to obtain treatment or payment or eligibility for benefits.

Please initial for consent to leave voicemails/texts _____

TELEHEALTH CONSENT

I understand that telehealth appointments involve sharing my medical information electronically and I need to check with my health insurance plan to see if telehealth visits are covered. I understand that I will be asked to confirm my identity and current location to the provider (or staff) at the start of my appointment.

I understand that telehealth visits carry some level of risk including but not limited to:

- My computer, tablet, or phone may not be private and secure.
- My healthcare provider cannot examine me as closely during a telehealth visit, and this may make it harder to diagnose and effectively treat me.

By initialing below, I agree to use telehealth visits with my Pacific Coast Care provider and assume all associated costs if not covered by my insurance.

Please initial for telehealth consent _____

GENERAL CONSENT TO TREAT

I consent to receive diagnosis, medical care, and treatment that is considered necessary or recommended by my provider(s) at Pacific Coast Care, including services through the use of telehealth technologies, such as telephonic and interactive audio-visual communications and other virtual care through the patient portal. Providers include physicians, Nurse Practitioners, Physician Assistants, and staff. I acknowledge that no guarantee can be made concerning the results of treatments. I understand that if specific procedures are recommended, I may be asked to read and sign additional consent forms prior to the procedure.

I have the right to discontinue services at any time and the right to discuss treatment plans with my physician about the purpose, potential risks and benefits of any test ordered, and ask questions.

I consent to the use of the electronic prescription system, which allows prescription history and related information to be electronically shared between my providers and my pharmacies. I also give permission to send or fax immunization records, completed forms, or notes to my school or employer upon my request. I understand that certain circumstances require mandatory disclosure to organizations such as the state health department and that this entity participates in the statewide immunization registry, which complies with federal health information privacy laws.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. By signing below, I acknowledge that this consent will remain effective until it is revoked in writing.

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

GENERAL CONSENT TO TREAT A MINOR (FOR PATIENTS UNDER 18)

I, the undersigned parent/legal guardian of the minor named below, hereby give my informed consent for Pacific Coast Care and its physicians, nurse practitioners, physicians assistants, nurses, or other healthcare staff to examine, diagnose, and provide medical treatment to my minor child as deemed medically appropriate. This includes, but is not limited to, routine medical care and evaluations, preventive care and immunizations (as discussed with me), diagnostic testing and procedures, and treatment of acute and chronic medical conditions.

In the event of an emergency where I cannot be reached, I authorize the provider to administer such emergency medical treatment as is necessary to protect the health or life of my child. I understand that I will be solely responsible for any charges, fees, or expenses incurred as a result of the treatment provided to the minor.

I also authorize and consent to medical care provided for the minor in my absence when he/she is accompanied by a designated adult chaperone or coming to the office by himself/herself.

Agree _____ Disagree _____ _____ ***Initial here***

This authorization shall remain effective until revocation in writing by the undersigned.

Parent/Legal Guardian Name (print): _____

Relationship to Minor: _____

Signature: _____ Date: _____

FINANCIAL POLICY

AGREEMENT TO PAYMENT POLICY I acknowledge that I received a copy of PROHEALTH PARTNERS, INC./Pacific Coast Care, 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./Pacific Coast Care, 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. (dba Pacific Coast Care), 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. (dba Pacific Coast Care),, 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 _____

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 _____ (date). The acknowledgement was not obtained because:

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

Signature:_____

Name of the patient:_____

Name of Staff Member:_____

Date:_____

PACIFIC COAST CARE

Today's Date: _____

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____

Past Medical History: *Check any conditions that you have or have had.*

- ☐ Hypertension (high blood pressure)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Diabetes (type I or II)
- ☐ Heart disease
- ☐ Lung disease (e.g. asthma or COPD)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Gastrointestinal disease
- ☐ Endocrine disease (including thyroid)
- ☐ Urinary problems (bladder or prostate)
- ☐ Arthritis or chronic joint or back pain
- ☐ Allergies
- ☐ Anxiety or Depression
- ☐ Skin disorders (e.g. eczema, psoriasis)
- ☐ Autoimmune disorders
- ☐ Cancer (specify type): _____
- ☐ Other: _____
  _____

Past Surgical History/Previous Hospitalizations: *Include the year of surgery/hospitalization.*

_____

_____

Medications: *List all medications (including over-the-counter), dosages, and how often taken.*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: *List all allergies to medications, foods, etc. or indicate none.*

_____

Family History:

	Father	Mother	Brother	Sister	Other (specify)
High blood pressure					
High cholesterol					
Diabetes					
Heart disease					
Anxiety or Depression					
Cancer *(specify type)*: _____					
Other: _____					

Social History and Habits:

Marital Status: _____ # of Children: _____

Place of Birth: _____

Occupation (current and past): _____

Smoking status: Never _____ Current _____ Former _____

If so, how much (cigarettes/day)? _____ How long? _____ Quit date? _____

Alcohol Use: How many drinks/wk? _____

Caffeine Use: Type and how many drinks/wk? _____

Recreational Drug Use (type and frequency): _____

Exercise (type and minutes/week): _____

List any other providers/medical specialists you see:

_____

_____

_____

Screening/Immunizations: *Please list approximate date completed.*

		Vaccinations:	
Colon Cancer Screening	_____	Tetanus (Tdap/Td)	_____
Mammogram/Breast Cancer Screening	_____	Pneumococcal	_____
Bone Density/Osteoporosis Screening	_____	Shingles	_____
Pap Smear/Cervical Cancer Screening	_____	Other	_____

Women's Health History (if applicable):

First Day of Last Menstrual Period _____ Age of First Menstrual Period _____

Total # of Pregnancies _____ Total # of Live Births _____ Age of Menopause _____

Anything else you would like us to know?:

_____

_____

PACIFIC COAST CARE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date _____

Patient's Last Name | First Name | Date of Birth

Address | City | State | Zip Code

Phone Number | Email Address | Purpose of Release (e.g. Patient request)

I hereby authorize and direct the health care provider named below to release my health records to:

Pacific Coast Care
10861 Cherry St, Suite 105
Los Alamitos, CA 90720
Phone (562) 259-8881 / Fax (562) 259-8887

Name of Physician/Health Care Provider/Other _____

Address _____ City/State/Zip Code _____

Phone Number _____ Fax Number _____

This request and authorization applies to:

- ☐ All Healthcare Information
- ☐ Healthcare information rendered to me during the period: From _____ to _____
- ☐ Other: _____

I expressly authorize and consent to the disclosure of my health information related to (check all that apply):

☐ Alcohol/Substance Abuse ☐ Mental Health ☐ STIs (including HIV/AIDS) ☐ Genetic Testing/Counseling
☐ Communicable Diseases ☐ Reproductive Health

_____

Patient or Authorized Representative Signature (for specific disclosures) *Date*

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. All patient care information shall be regarded as confidential and available only to authorized users. Medical records include any protected health information (PHI).

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. This authorization shall expire one year from the date signed. I understand this authorization is voluntary and I may refuse to sign it. My health care treatment will not be affected if I refuse to sign. I have a right to receive a copy of this authorization.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

_____

Patient or Authorized Representative Signature **Date**

_____

Patient or Authorized Representative Name