PATIENT NAME: _____
LAST FIRST MI

MAILING ADDRESS: _____

HOME (IF DIFFERENT THAN MAILING ADDRESS): _____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY PHONE: _____ SEX: M F BIRTH DATE: _____

SECONDARY PHONE: _____ EMAIL: _____

EMPLOYER: _____ WORK PHONE: _____

SOCIAL SECURITY#: _____ DRIVER'S LICENSE # _____

RACE: _____ ETHNICITY: _____ PRIMARY LANGUAGE: _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _____

SECONDARY INSURANCE COMPANY NAME: _____

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER'S EMPLOYER: _____ RELATIONSHIP: _____

I UNDERSTAND THAT NURSE PRACTITIONERS MAY BE INVOLVED IN MY HEALTHCARE AT THIS OFFICE.

ASSIGNMENT OF BENEFITS AND FINANCIAL STATEMENT

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO HILLCREST INTERNAL MEDICINE, A MEDICAL CORPORATION, OR ANY OTHER ASSISTING PHYSICIANS, FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I AGREE TO PAY ALL COSTS OF COLLECTIONS AND ANY REASONABLE ATTORNEY'S FEES INCURRED. I HEREBY AUTHORIZE THIS HEALTHCARE PROVIDER TO RELEASE, TO THE INSURANCE COMPANY, ANY INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

MEDICAL POLICY

I UNDERSTAND AS A PATIENT THAT IF I DECLINE OR FAIL TO DO DIAGNOSTIC TESTS THE PRACTITIONER CAN NOT BE RESPONSIBLE FOR THE CONSEQUENCES. I UNDERSTAND THAT IF I DO NOT HEAR ABOUT TESTS IT IS MY RESPONSIBILITY TO CONTACT MY PRACTITIONER FOR RESULTS.

SIGNATURE _____ DATE _____

Hillcrest Internal Medicine
4060 Fourth Avenue, Suite 505
San Diego, CA 92103
619 298-1318

HEALTH QUESTIONNAIRE DATE:_____

NAME		AGE	DATE OF BIRTH
STREET ADDRESS	CITY	ZIP	TELEPHONE (circle one: cell/ home)

HISTORY OF PAST ILLNESS: (Please list prior medical problems requiring treatment, or hospitalization)

CHILDHOOD DISEASES: (Circle if you have had this illness)

Measles	Diabetes
Mumps	Cancer
Chicken Pox	Rheumatic Heart Disease
Tubercolosis	Congenital Abnormalities

PAST SURGERIES AND YEAR OF SURGERY:

CURRENT MEDICATIONS AND SUPPLEMNTS

NAME /DOSE/ HOW OFTEN:

ALLERGIES TO MEDICATIONS AND REACTION

Previous Primary Care:

_____

Hillcrest Internal Medicine
4060 Fourth Avenue, Suite 505
San Diego, CA 92103
619 298-1318

SOCIAL HISTORY

Marital Status: _____ Number of Children_____

Current/Prior Occupation:_____ Is Sex Life satisfactory? _____

Do you have dependents at home?:_____ More than one sexual partner?_____

What is your sexual orientation? ☐ Heterosexual ☐ Homosexual ☐ Bisexual

Tobacco Use: ☐Never or ☐ ____ Packs a day since what age? _____

Alcoholic Beverage Use: How many drinks per week? _____

FAMILY HISTORY

Family	**Alive at Age or**	**Deceased at Age**	**Health Problems**
Father			
Mother			
Grandmother (s)			
Grandfathers (s)			
Brother (s)			
Sister (s)			
Children			
Other Family			

Circle if this runs if family: Cancer Tuberculosis Diabetes Heart Trouble
High blood pressure Stroke Bleeding Tendency Insanity

SYSTEMIC REVIEW: (Please circle any of the following that relate to you)

General:
- Recent weight change
- Insomnia

Head/Eye/Ears/ Nose/Throat:
- Headaches
- Dry Eyes
- Wear Glasses
- Bloody Nose
- Ringing in Ears
- Poor Hearing
- Sinus Trouble
- Runny Nose
- Sore Throat

Skin:
- Eczema
- Rash/Abnormal lesion
- Yellowing of skin

Neck:
- Thyroid Trouble
- Mass or Nodule in neck
- Stiffness

Respiratory:
- Cold symptoms
- Shortness of breath
- Asthma
- Wheeze/Cough

Musculoskeletal:
- Back pain
- Varicose Veins
- Pain in legs with walking

Neurological:
- Paralysis
- Convulsions/Seizures
- Psychiatric Illness

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Cardiovascular:

- Palpitations
- Chest Pain
- Shortness of breath when lying flat
- Heart Murmur
- Swelling in hands or feet

Gastrointestinal:

- Diarrhea
- Constipation
- Acid Relfux/Heart Burn
- Bloody or black stools
- Abdominal Cramping
- Hemorrhoids

Hematologic:

- Bleed easily
- Anemia
- Phlebitis
- Bruise easily

Endocrine

- Thyroid Disease
- Hormone Therapy
- Hair growth changes
- You get colder easily

Genitourinary/Gyn:

- Frequent urination
- Night time urination
- Burning/painful urination
- Urine Incontinence (Loss of control)
- Kidney Stone

FEMALES:
Age menses (period) began_____
How many days apart are they?_____
Number of pregnancies_____
Number of miscarriages_____
Number of live births____
Last Pap Smear_____

Last Menstrual Period_____
Last Mammo_____

Health Maintenance:
Last Colonoscopy:
Bone Density:
Tetanus:
Flu Shot:
Pneumonia Shot:
Shingles Shot:

Your Height_____
Your Weight_____

Source of Information, if other than the patient:_____

Additional Notes:

NOTICE OF PRIVACY PRACTICES

HILLCREST INTERNAL MEDICINE

Penny Mason, Office Manager, 619-298-1318

Effective Date 03-30-2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or following your death.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. Sign-in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in., We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you

may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office of Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 (fax)
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Hillcrest Internal Medicine
4060 Fourth Ave
Suite 505
San Diego, CA. 92103

Prescription History Consent

I hereby grant permission to Hillcrest Internal medicine to obtain my external prescription history from all sources to better able my doctor's coordination of my external medical care.

As per the HIPPA regulations, this information will be kept strictly confidential.

_____

Name (print)

_____

Signature

_____

Date

HIPPA RELEASE AUTHORITY:

I intend for the person named below to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by (HIPPA), 42 USC 1320d and 45 CFR 160-164. I Authorize:

a. Any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Information Bureau, Inc. or other health care clearing house that has provided me treatment or services, or that has paid for or is seeking payment from me of such services.

b. To give, disclose and release to the person named below, without restriction: All of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, to include all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness and drug or alcohol abuse.

Name:_____

Address:_____

Telephone:_____

The authority given shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority, in writing, and deliver it to my health care provider.

Signature:_____

Address:_____

Telephone:_____

Date:_____

HILLCREST INTERNAL MEDICINE

To better serve you, our patients, we have implemented the following prescription and office policies:

Prescription refills:
If you have refills remaining on your prescription please contact your pharmacy to request additional refills.
Please plan ahead, refills usually require 48 hours to process.
Call your pharmacy to check on the status of your prescription before you call our office.

For written prescriptions and mail order pharmacies, including but not limited to, Prescription Solutions, Express Scripts, Medco, CareMark, please notify us in writing. Include the:

- Name of the medications
- Dosages
- Number of tablets you take per day
- How many days supply your insurance will cover

Please include a self addressed stamped envelope for all prescriptions that need to be mailed back to your home.

Lab slip request:
For all non urgent lab slip requests, please submit in writing; please include a self addressed stamped envelope.

Phone calls:
All urgent phone calls will be returned as promptly as possible. Please recognize that on some very busy days we may not be able to return calls until the end of the day. A medical assistant will call you when urgent prescription requests, such as antibiotics, have been called to your pharmacy.

All non-urgent calls after 4:00 p.m. will be handled the following work day.

After Hours:
Please do not request routine refills after hours or on weekends. Controlled substances will not be refilled after office hours, as the doctor does not have access to your chart.

It is the patient's responsibility to make Co-pays at the time of service.

There will be a $25 fee for missed appointments without a 24 hour notice.

If you're late for your appointment you may have to re-schedule.

It is the patient's responsibility to make sure we have all your updated information, i.e.: current phone number, address, insurance information, etc.

I understand as a patient that if I decline or fail to do diagnostic tests the practitioner can not be responsible for the consequences. I understand that if I do not hear about tests after two weeks, it is my responsibility to contact my practitioner for results.

Signature _____ Date _____

Hillcrest Internal Medicine
4060 Fourth Ave
Suite 505
San Diego, CA 92103

WHEN THIS FEATURE BECOMES AVAILABLE

E-MAIL CONSENT

I hereby grant permission to Hillcrest Internal Medicine to send correspondence; which may include test results, letters regarding results, appointment confirmation, questions regarding medication, health issues, etc. to my E-mail.

E-mail address: _____

Name Print _____

Signature _____ Date _____