Western Sierra Medical Clinic
Better Health Together

New Patient Health Questionnaire

For Office Use Only (choose one):
☐Primary ☐Pain ☐Dental
☐Addiction Medicine
☐Other_____

www.wsmcmed.org

PATIENT'S NAME: _____ DATE OF BIRTH: _____ DATE: _____

The following information will help you and your provider focus on the health topics and concerns that are affecting you or are more likely to affect you. Please fill out the questions as completely as possible.

PERSONAL MEDICAL HISTORY:

Please indicate each of your medical problems by marking the appropriate box below:

☐ Asthma	☐ Stroke	☐ Rheumatic Fever			
☐ Emphysema/ Lung Disease	☐ Arthritis	☐ Hemorrhoids/Rectal Bleeding			
☐ Pneumonia	☐ Hepatitis	☐ Hernia			
☐ Tuberculosis	☐ Kidney Disease	☐ Irritable Bowel			
☐ Heart Attack	☐ Seizures/Epilepsy	☐ ADD	☐History	☐Currently Experiencing	☐Current Prescription
☐ Angina	☐ Head Injury	☐ Chronic Pain	☐History	☐Currently Experiencing	☐Current Prescription
☐ High Blood Pressure/Heart Disease	☐ Headaches	☐ Anxiety	☐History	☐Currently Experiencing	☐Current Prescription
☐ Stomach Ulcers	☐ Cataracts	☐ Depression	☐History	☐Currently Experiencing	☐Current Prescription
☐ High Cholesterol	☐ Colon Polyps	☐ Other Mental Health Diagnosis	☐ History	☐Currently Experiencing	☐Current Prescription
☐ Thyroid Disease	☐ Cancer (If yes, what type?)				
☐ Glaucoma	☐ Suicidal Thoughts?				

List all surgeries and hospitalizations (including psychiatric hospitalization):

Type	Year	Medical	Psychiatric	Hospital, City, State
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

Are you allergic to any medications or foods? Please list and note your reaction.

Food/Medication	Reaction

Grass Valley Site
844 Old Tunnel Road
Grass Valley, CA 95945
530-274-9762 / FAX: 530- 273-7255

CoRR Site
180 Sierra College Drive
Grass Valley, CA 95945
530-802-0400 / FAX: 530-273-7255

Downieville Site
209 Nevada Street
Downieville, CA 95936
530-289-3298 / FAX: 530-289-3159

Please list all medications that you are taking, including strength, and how often. Include all non-prescription medications, vitamins and herbal supplements. Please include any medications you have taken in the last 6 months. If you need more room, please attach additional list.

Name	Strength	How often	Condition	Currently Taking?

Do you see any other medical providers or specialists currently? If so, please list their names and what services or medications they are providing to you. **Please complete a records request for each provider/specialist.**

Name	Service/Medications

FAMILY MEDICAL HISTORY:

If any blood relative has suffered from the following conditions, check the box and **indicate which relative**:

☐ Heart Disease	☐ Stroke	☐ Asthma	☐ Glaucoma
☐ Diabetes	☐ High Blood Pressure	☐ Emphysema/Lung Disease	☐ Mental Health Condition
☐ Thyroid	☐ High Cholesterol	☐ Alzheimer's/ Dementia	☐ Substance Abuse
☐ Neurological Disorder	☐ Genetic Disorder	☐ Cancer (If yes, what type?)	

PREVENTATIVE HEALTH CARE:

A. Year of Last Vaccine:

Tetanus: _____ Pneumonia: _____ Pneumovax: _____ Prevnar 13: _____ Flu: _____ Shingles: _____

Have you had Chicken Pox? Yes ☐ No ☐ Have you been vaccinated for Chicken Pox? Yes ☐ No ☐

B. Colonoscopy:

Year of Last Colonoscopy: _____ Doctor: _____

C. Women Only:

Date of last Mammogram: _____ Doctor: _____

Date of last PAP: _____ Doctor: _____

Date of last menstrual period: _____ Have you had a hysterectomy? _____ Full ☐ Partial ☐

Are you pregnant? _____ OB Doctor: _____

D. Men Only:

Date of last Prostate Exam: _____ Doctor: _____

Date of last PSA (Prostate Blood Test): _____ Doctor: _____

E. Bone Density

Have you had a Bone Density Test? Yes ☐ No ☐

If so, when? _____ Doctor: _____

F. Smoking

Are you a smoker? Yes ☐ No ☐

If you smoke, how many cigarettes do you smoke a day? _____, are you interested in quitting? Yes ☐ No ☐

How soon after you wake up in the morning do you smoke your first cigarette? _____

G. Alcohol

Do you drink alcohol? Yes ☐ No ☐ How many drinks do you have in a day? _____

H. Diabetes

Are you diabetic? Yes ☐ No ☐ Date of last A1C: _____

Date of last eye exam: _____ Do you do daily foot exams? Yes ☐ No ☐

Do you have any disabilities that you would like us to know about?

☐ Disability related to vision
☐ Disability related to hearing
☐ Disability related to communication
☐ Physical Disability
☐ Learning Disability
☐ I am requesting appointment for paperwork for disability

If so, what reasonable accommodations could we make to assist you (for example, large print education materials or accommodations for a wheelchair)?

_____

_____

_____

Do you have a living will or advanced directive? Yes _____ No _____

If no, are you interested in speaking with a staff member about this? Yes _____ No _____

Do you have a conservator/legal guardian or proxy? Yes _____ No _____

Please indicate the problem you are here for today: _____

_____

_____

FEEDBACK:

How did you hear about Western Sierra Medical Clinic?

☐ Newspaper ☐ Facebook ☐ Referral from medical provider

☐ Radio ☐ Neighbor/friend ☐ Other: _____

It may take some time to obtain and review your health information and enroll you as a patient.

If you have an immediate need, please visit our Urgent Care unit.

HIPAA Policy Notice and Acknowledgement

I acknowledge that I have read and understood the Western Sierra Medical Clinic ***HIPAA NOTICE OF PRIVACY PRACTICES.*** A copy can be furnished to you upon request.

Patient or Personal Representative Signature: _____ Date: _____

If Personal Representative's signature appears above, please describe Personal Representative's Relationship to the Patient:

Relationship to Patient: _____

Authorization to Consent to Treatment

_____ _____
Patient's Name **Date**

_____ _____
Address **Date of Birth**

_____ _____
City, State, Zip **Phone**

_____ _____
Responsible Party (Parent or Guardian) **Alternate Phone**

The undersigned does hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician/provider on the Medical staff of ***Western Sierra Medical Clinic.*** Diagnosis or treatment is rendered at the office of the physician/provider or at the hospital.

MINORS-(I) (We), the undersigned, parent(s)/guardian(s) of _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician/provider on the Medical staff of ***Western Sierra Medical Clinic.*** Treatment is rendered at the office of the physician/provider or at the hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/provider in the exercise of his/her best judgment may deem advisable.

This authorization shall remain effective for one year from the date signed, unless sooner revoked in writing.

_____ _____ _____
Patient or Guarantor Signature (Parent or Legal Guardian) **Print Full Name** **Date**

Relationship to Patient: _____

Grass Valley Site
844 Old Tunnel Road
Grass Valley, CA 95945
530-274-9762 / FAX: 530- 273-7255

CoRR Site
180 Sierra College Drive
Grass Valley, CA 95945
530-802-0400 / FAX: 530-273-7255

Downieville Site
209 Nevada Street
Downieville, CA 95936
530-289-3298 / FAX: 530-289-3159

Western Sierra Medical Clinic
Better Health Together

Patient Registration

www.wsmcmed.org

PATIENT INFORMATION

o Mr. Last Name First Name Middle o Male
o Mrs.
o Miss o Female

Previous Name(s)(Maiden Name):

Home Address (Number and Street) Mailing Address (if different) Email Address

City State Zip Code | Patient Employed By

Home Phone ( ) | Work Phone Ext. # ( ) ( ) | Date of Birth | Patient Social Security Number -- --

Race (check one): ☐ Asian ☐ Pacific Islander ☐ Asian Pacific ☐ Native Hawaiian ☐ Native American
☐ Black (not of Hispanic origin) ☐ Caucasian (not of Hispanic origin) ☐ Hispanic (Spanish/Latin American origin) ☐ Other _____

What is your ethnicity? Hispanic ☐ Non-Hispanic ☐ | Family Size (per household) | Annual household income | Primary Language

US Citizen? Yes ☐ No ☐ Naturalized Citizen? Yes ☐ No ☐ | Are you a Veteran? Yes ☐ No ☐ | Are you a migrant farm worker? Yes ☐ No ☐ | Are you Homeless? Yes ☐ No ☐

In Case of Emergency Notify | Relationship to Patient | Work Phone Ext. # ( ) ( ) | Home Phone ( )

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT

o Mr. Last Name First Name Middle | Relationship to Patient | Home Phone ( )
o Mrs.
o Miss

Billing Address (if different from Patient's) City State Zip Code

Employed By | Job Title/Department | Work Phone Ext. # ( ) ( )

Employer Address (Number and Street) | Guarantor's Social Security # -- -- | Guarantor's Date of Birth

City State Zip Code

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Group Number	Subscriber I.D.
Subscriber Name	Subscriber Date of Birth	Plan Name and Number

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Group Number	Subscriber I.D.

Western Sierra Medical Clinic
Better Health Together

Financial Agreement

www.wsmcmed.org

PATIENT'S NAME: _____ DATE OF BIRTH: _____

We at Western Sierra Medical Clinic are committed to providing the highest level of professional medical care and personal service. By selecting our medical group you have expressed confidence in our ability to meet this commitment. Our physicians and staff wish to welcome you and thank you for choosing Western Sierra Medical Clinic. Once you have finished reading this policy, please turn to the last page of this form to sign and date where indicated to confirm that you have read and understand the following:

PAYMENT PROCEDURE

For every commitment there is an obligation. At Western Sierra Medical Clinic we are committed to providing quality medical care and services. Conversely, we feel it is the guardian/patient's responsibility to meet their financial obligation. As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan.

While it is our intention to assist you, it is still your responsibility to ensure that all services rendered by Western Sierra Medical Clinic on your behalf are paid in full within thirty (30) days of the statement date. In some instances Western Sierra Medical Clinic cannot bill your insurance carrier for you in such cases as auto accidents, insurance liens, etc. However, you will be provided all of the information necessary to submit a claim to your insurance company.

The patient is responsible for co-payments, co-insurance and services not covered or approved by their insurance carrier if that carrier is contracted with Western Sierra Medical Clinic. This financial responsibility also applies if your insurance carrier is not contracted with Western Sierra Medical Clinic. However, as a courtesy to you, non-contracted insurance carriers may be billed for your reimbursement.

It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered. Western Sierra Medical Clinic accepts cash, checks or major credit cards. Checks should be made payable to Western Sierra Medical Clinic. ***A $32.00 FEE WILL BE CHARGED FOR THE FIRST CHECK RETURNED BY THE BANK AND A SERVICE FEE OF UP TO $35 FOR EACH SUBSEQUENT CHECK RETURNED BY THE BANK TO THAT SAME PAYEE Cal. Civ. Code 1719 (2003).***

Please make every effort to let us know if your insurance carrier (primary or secondary insurance), or your personal information (home address, employer, phone number, etc.) has changed since your last visit. We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have. I agree that I will be liable for any attorney fees and costs in the event any collection of unpaid balances is deemed necessary by Western Sierra Medical Clinic.

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medi-Cal, government and any other third party benefits made on my behalf and/or on behalf of all members covered on my insurance plan be made directly to Western Sierra Medical Clinic, or services furnished by that provider.

If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I authorize the release of medical information needed to determine benefits or benefits payable to related services. I permit a copy of this authorization to be used in place of the original.

I certify that, to the best of my knowledge, the patient registration information is true. In the event my account becomes delinquent, I authorize the creditor or his agent to make a credit investigation, including employment verification.

By agreeing to the terms of the supplier, I agree that should an account become delinquent and be referred to a collection agency for collection, the undersigned shall be liable for court costs and attorney fees. All delinquent accounts shall accrue interest at the legal rate.

_____	_____	_____
Patient (or Guardian) Signature	**Print Full Name**	**Date**

NO-SHOW POLICY

I understand that WSMC has established a no-show policy in order to maintain quality healthcare to all patients of the clinic. A no-show is when I call and cancel an appointment with less than 24 hours of the appointment or I do not show up for a scheduled appointment. For all medical services, I understand that after two no-shows, I will be placed on scheduling probation.

For all dental services, I understand that after one no-show, I will be placed on scheduling probation. I understand that scheduling probation means that I will be able to schedule appointments, but I must call and confirm the appointment the day before. If I do not confirm the appointment, the appointment will be cancelled. If I show for the unconfirmed appointment, I will not be seen. If I don't show for an appointment after confirming it, I will be considered for discharge from the practice. I also understand that after I demonstrate a pattern of attending my appointments consistently, I can be considered for removal of the scheduling probation.

For all Behavioral Health services, I understand that if I no-show an appointment once, I will not be able to schedule another appointment; instead I would be on stand-by status (I can come in and wait for an opening to occur) or call-in status (call in the morning to see if there is an opening on the same day). If I fail to show for a call-in appointment, I can be considered for discharge from Behavioral Health services (although could still be seen for medical and dental services). The Business Office Staff and Management welcome the opportunity to discuss any aspect of the financial and no-show-policies.

Patient or Guardian Signature: _____ Date: _____

If Guardian, Relationship to Patient: _____ Date: _____

Staff Signature: _____ Date: _____

Western Sierra Medical Clinic

Better Health Together

www.wsmcmed.org

Notice of Prescription Protocol

Dear Prospective Patient:

Greetings, and welcome to the Western Sierra Medical Clinic practice. We look forward to assisting you in achieving your health goals and providing you with complete and comprehensive services through a dynamic team approach.

As a new patient to our health clinic, please note that your provider will make a comprehensive assessment of your health, and will work to create a health plan to best meet your health needs. **Your provider may or may not choose to prescribe the same medications that you may have been prescribed to you in the past.** Our providers utilize current best practices and information to create treatment plans.

Please sign below to acknowledge that you have read this information and agree to work within this Western Sierra Medical Clinic policy. In our continuing efforts to provide a medical home and continuity of care, we look forward to a long and mutually beneficial health relationship.

Notice of Medical Records Protocol

As a new patient to our health clinic, please note that your provider will make a comprehensive assessment of your health, and will work to create a health plan to best meet your health needs. **Your provider may or may not be able to address current conditions without receiving your previous medical records. A follow-up visit will be scheduled after your initial appointment to discuss your when the previous medical records are received.**

Our providers utilize current best practices and information to create treatment plans.

Please sign below to acknowledge that you have read this information and agree to work within this Western Sierra Medical Clinic policy. In our continuing efforts to provide a medical home and continuity of care, we look forward to a long and mutually beneficial health relationship.

By signing below, I understand that I may not be prescribed medications that I have been previously prescribed.

_____	_____	_____
Patient (or Guardian) Signature	**Print Full Name**	**Date**

Grass Valley Site
844 Old Tunnel Road
Grass Valley, CA 95945
530-274-9762 / FAX: 530- 273-7255

CoRR Site
180 Sierra College Drive
Grass Valley, CA 95945
530-802-0400 / FAX: 530-273-7255

Downieville Site
209 Nevada Street
Downieville, CA 95936
530-289-3298 / FAX: 530-289-3159

Western Sierra Medical Clinic
Better Health Together

Information Sharing Consent

www.wsmcmed.org

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

Here at Western Sierra Medical Clinic we value the privacy of your health information. To that end, we won't leave detailed messages for you on voicemails or with other people without your express permission. In the event you do have a voicemail you would like us to leave detailed messages on, or family members or friends you would like staff to share your medical information with, please fill out the form below. To revoke permissions after this form is completed, please submit the request in writing.

LEAVING DETAILED MESSAGES:

I, _____, give permission for the staff of Western Sierra Medical Clinic to **leave detailed health information** on the voicemail at this number: _____

RELEASING INFORMATION:

As the patient whose name is listed above, or their legal guardian, I give permission for the staff of Western Sierra Medical Clinic to discuss any information related to the patients' health care or medical condition, including those related to any behavioral health visits, and to make appointments on the patients' behalf. If you would like to limit the information shared, please write any exceptions in the space below.

#1 **Name:** _____ **DOB:** _____ **Relationship:** _____

#2 **Name:** _____ **DOB:** _____ **Relationship:** _____

As our standard practice, when calling we identify ourselves as staff of the health clinic and/or provider you see. Materials we send by physical or electronic means will be marked with the health clinic logo and name. If you would like an additional level of confidentiality, please check the boxes below. While we will take these additional steps, please note that we make no guarantee that an enterprising individual won't determine where we're calling from (through our call back number for example).

☐ Mail in an unmarked envelope	☐ Staff identify themselves by first name only	☐ Only call this phone number:	☐ Only contact me through the patient portal (*if applicable)*

Your Name: _____ Signature: _____

Relationship (if not self): _____ Date: _____

Western Sierra Medical Clinic
a californiahealth+ center

My Health Gateway
Patient Portal Enrollment

Western Sierra Medical Clinic uses the latest technologies to increase our quality of care, and to make it easier for you to access your health records and communicate with your health care team.

If you have an email address and access to a computer, this form will be used to enroll you in our online patient portal, which we call ***"My Health Gateway: Your Online Wellness Connection."*** The Gateway is convenient, secure, and lets you log on from home (or from any computer, tablet or smartphone), at your convenience, to do the following:

- View upcoming appointments (date and time)
- Request a medication refill
- View and download/print your personal health record, including your medications, immunizations, and lab results.

Your personal information is safe on the Gateway. Access to your information requires the entry of your user name, a password, and the correct answer to your security questions.

Adults 18 years of age and older can use the portal. It is not available for minors or for parents to see their children's records.

You will receive an email notification of your Gateway enrollment after returning your New Patient Packet to us and being accepted as a patient. The email will contain:

- A link to the Gateway website
- Your user name
- A temporary password

Be sure to set up your Gateway account when you get our email, by logging in with your temporary password, then choosing your own password.

We welcome your active use of the Gateway so you can be a full partner in maintaining better health. Once you've completed your enrollment by logging in, you will be able to access the Gateway at any time by going to our website at ***www.wsmcmed.org.*** Click on the colorful, round "My Health Gateway" button at the top of the home page. If you have questions or problems with the Gateway, please call us during regular business hours.

Please print clearly:

Name:_____ Email address:_____

☐ I do not have an email address or easy access to a computer, so cannot use the Gateway.

STAFF USE ONLY: ☐ Web-enabled on (date) _____ by (initials): _____

Western Sierra Medical Clinic
Better Health Together

Authorization to Disclose Health Information

www.wsmcmed.org

PATIENT DATA

Full Name (Please Print): _____ Date of Birth: _____

AKA: _____ SSN: _____-_____-_____

Address: _____ Home Phone: _____

City, State, Zip: _____ Work Phone: _____

AUTHORIZATION - INFORMATION TO BE RELEASED *FROM*:

Facility/Physician: _____ Patient ID: _____

Address: _____ Medical Records #: _____

City, State, Zip: _____ Account #: _____

Phone: _____ Fax: _____ HIPAA Log: Yes ☐ No ☐

INFORMATION TO BE DISCLOSED *TO*:

Western Sierra Medical Clinic
844 Old Tunnel Road
Grass Valley, CA 95945
Phone: 530-274-9762
Fax: 530-273-7255

PURPOSE OF RELEASE:

☐ Continuing Care
☐ Consultation
☐ Second Opinion
☐ Patient's Request
☐ Other

This authorization is valid for six (6) months from the date of consent or expires on the following specified date, event, or condition: _____. I understand that by completing this request form I will be subject to the new patient review process that will determine if I will be accepted as a patient at this clinic.

I AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

		Last 2 Years
☐ Office Medical Records	From (date) _____ to (date) _____	☐
☐ Imaging Records (X-rays, etc)	From (date) _____ to (date) _____	☐
☐ Lab / Pathology Records	From (date) _____ to (date) _____	☐
☐ Consultation Reports	From (date) _____ to (date) _____	☐
☐ Other: _____	From (date) _____ to (date) _____	☐

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Western Sierra Medical Clinic
Better Health Together

Authorization to Disclose Health Information

CONTINUED

SPECIAL CONSENT / CONDITIONS

The following records require the patient's initials and date they will be released.

☐ Psychiatric Records Initials_____
☐ Alcohol / Drug Abuse Records Initials_____
☐ STD / AIDS / HIV Records Initials_____

MEDICAL RECORD COPYING SERVICES

The medical records you requested are copied by EGF Business Services. EGF is under agreement with provider to copy all medical records when an authorized release is furnished.

If you wish a copy for yourself of the past two-year's records, there will be a maximum charge of $15.00. If you require a copy of more than two years, there will be no maximum fee and EGF Business Services will contact you for this service.

The photocopies have been made from the Doctor's original medical records. Federal and State laws protect the confidentiality of the records.

If you should have any questions regarding the records, please contact medical records at 530-274-9762.

SIGNATURE

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to electronic disclosures by the recipient and may no longer be protected by federal or state law. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I further understand there may be a fee associated with my request for the release of information as governed by the California Health and Safety Code §123110.

_____ _____ _____

Patient (or Legal Representative) **Relationship (if not patient)** **Date**

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