Family Care Specialists (FCS) Medical Group
Patient Registration

PATIENT INFORMATION

Last Name	First Name	Initial	Previous Name (Maiden)

Street Address	City	State Zip
Home Telephone ( )	Employer Telephone ( )	Cellular Telephone ( )
Birth Date Age Gender ☐ M ☐ F	Marital Status ☐ Single ☐ Married ☐ Widow ☐ Divorced	Social Security Number
E-Mail Address	Occupation	Driver License Number
Employer Name	Date Employment Began	Ethnicity
Employer's Street Address	City State Zip	Preferred Language
Referred by	Do you request interpreter services? ☐ Yes ☐ No	

SPOUSE / GUARDIAN INFORMATION

Last Name	First Name	Initial	Relationship to Patient	Birth Date	Gender
					☐ M ☐ F

Street Address	City	State Zip
Home Telephone ( )	Employer Telephone ( )	Cellular Telephone ( )
Driver License Number	Social Security Number	Birth Date
Employer Name	Date Employment Began	Occupation
Employer's Street Address	City	State Zip

INSURANCE INFORMATION

Medicare Number: Part B: ☐ Yes ☐ No	Effective Date:	Medi-Cal Number:	Birth Date Gender ☐ M ☐ F
Policy / ID Number	Group / Local Number		Coverage / Plan Number
Insurance Company Name – Primary	Insured / Subscriber		Patient Relationship to Insured
Street Address	City State Zip		Telephone ( )
Policy / ID Number	Group / Local Number		Coverage / Plan Number
Insurance Company Name – Secondary	Insured / Subscriber		Patient Relationship to Insured
Street Address	City State Zip		Telephone ( )

EMERGENCY CONTACT

Last Name	First Name	Telephone	Relationship to Insured

Telephone Number in case of an emergency:

Assignment: I authorize payment of medical benefits to the under Signed physician or supplier for service described.

Lifetime Medicare Authorization ☐ Yes ☐ No Date:

Have you ever been here before: ☐ Yes ☐ No When?

Patient Signature _____ Date _____

PATIENT NAME:_____

DATE: _____ MRN: _____

To promote wellness and handle all your healthcare needs, Family Care Specialists Medical Group wants you to understand its policies. Please initial next to each policy to ensure you understand and have knowledge of them. If you would like clarifications of our policies please ask the receptionist or physician.

Policy	Initials
CONSENT FOR SERVICES/INFORMATION RELEASE: My request for an office visit serves as consent for routine office services, such as appropriate physical examination and routine blood or urine testing in the judgement of my physician. Specific consent will be obtained for more specialized services, if needed. I further agree that if I decided to leave without receiving treatment and / or the consent of my attending physician, neither said physician nor Family Care Specialists (FCS) Medical Corporation shall be liable for the consequences of such decision.	
COPAYMENT POLICY: Co-payments, if due, are payable at the time of check-in. Inability or unwillingness to comply with co-payments may lead to cancellation of a scheduled visit. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.	
NO-SHOW POLICY: Many of our offices may use an automated reminder system to help remind patients of upcoming appointments. However, timely cancellation of appointments remains the responsibility of our patients. If an appointment is cancelled with less than 3 hours notice, a missed visit maybe charged.	
FEE FOR FORMS: Completion of forms not directly related to patient care is not routinely covered by clinical visit fees or by insurance. Because these take a significant amount of physician time, we find it necessary to charge a fee for completion of such forms. Examples include: Jury Duty Excuse, Family Leave Act application, Sport Physicals, School Documents, DMV Plates or Placard Application, Disability, and Accident Reports.	
REFERRALS/AUTHORIZATION: Depending on your insurance, a referral or pre-certification from your physician or insurance plan may be required to see specialists or for specialized procedures. Such authorizations may require up to 7-10 working days for processing. Referrals for urgent services may be expedited based on medical necessity. Patients who choose to access specialty services without the necessary prior authorization or who elect to use a Point of Service option will be financially responsible for the services rendered.	
LATE POLICY: We make every effort to keep our office on time, barring any unforeseen emergencies, and appreciate your help. We ask you to arrive at least 15 minutes before your appointment time. In the event that you are unavoidably late, we will do our best to accommodate you, but may ask you to reschedule for later that day or another day.	
ELECTRONIC HEALTH INFORMATION: Family Care Specialists Medical Group uses computerized health records to ensure patient safety, accuracy of information, and continuity of care amongst different providers. Our physicians and staff also use secure e-mail to communicate within the Family Care Specialists Medical Group's System regarding non-urgent health matters and administrative issues. The physicians and staff may also leave voicemail messages for patients with non-confidential information.	
FEES FOR MEDICAL RECORDS: A reasonable cost based fee will be charged for providing copies of patient health information, including the cost of copying (supplies and labor), postage (if individual has requested that the information be mailed), and for preparation of any summary or explanation if agreed.	
MEDICATION REFILLS: Any medication refills may take 24-48 hours to complete. To best serve you, please make sure we have updated pharmacy information on file.	
FEE FOR NON-COVERED SERVICES: Family Care Specialists Medical Group routinely forwards records or other information necessary to process medical claims. Family Care Specialists is affiliated with Family Care Specialists IPA and shares information with Family Care Specialists Medical Corporation and its affiliate ancillary departments (ex. billing). There may be instances where your insurance does not cover certain injectable medications, immunizations and medical supplies. Patients bear full financial responsibility for all professional services rendered and charges for those services will be collected at the time of your appointment.	
FINANCIAL AGREEMENT: I hereby authorize insurance benefits to be paid directly to Family Care Specialists Medical Group/Family Care Specialists IPA. I agree that in consideration for services to be rendered by Family Care Specialists (FCS), I shall make prompt payments to the FCS account as bills are presented. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection, I shall pay the actual attorney fees and collection expenses.	

Thank you for taking the time to learn about our policies and procedures.

"I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. "

Signature: _____ **Date**: _____

If a minor, signature, name and date of parent/guardian:

_____

FAMILY CARE SPECIALISTS
Medical Corporation

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The confidentiality extends to all methods of communication which includes, written, electronic, verbal, or other.

PLEASE REVIEW IT CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, workers' compensation carrier, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Family Care Specialists (FCS). For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluated and promote quality. Your health information may be used as necessary to conduct training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers.

Law Enforcement: We will disclose medical information about you when required to do so by federal, state or local law.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Additional Uses of Information: Appointment reminders. Your health information will be used by our staff members to send or call you regarding appointment reminders.

Information About Treatment: Your health information may be used to send you information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health

and recovery of all patients who received one medication to those who received another, for the same condition. Research projects are subject to a special approval process. Before we disclose medical information for research, the project will have been approved thought this research approval process. We may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who are you.

Other Uses and Disclosures Require Your Authorizations: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights and under the federal privacy standards these include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Family Care Specialists (FCS) Medical Corporation Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practice: As permitted by law, we reserve the right to amend or modify our privacy practices. We will provide you with a revised notice or you may obtain a copy of the revised notice by accessing our web site or calling our office.

Complaints: If you would like to submit a comment or complaint about our privacy practice, you can do so by sending a letter outlining your concerns to our corporate office:

Family Care Specialists (FCS) Medical Corporation
5823 York Blvd., Suite 1
Los Angeles, CA 90042
Attn: Privacy Officer

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Patient Name:_____ D.O.B.: _____
(please print)

By signing this form, you acknowledge receipt of the Notice of Privacy Practice of Family Care Specialists (FCS) Medical Incorporation. Our Notice of Privacy Practices information is about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website: http://www.fcsmg.com/for-patients or ask the office receptionist for a copy. We will make every effort to provide you with a copy of the updated Notice of Privacy Practices upon your first office visit or after any new Privacy Practices are implemented.

If you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer.

I _____, acknowledge receipt of the Notice of Privacy
(Print name of Patient/Parent/Conservator/Guardian)

Practices of Family Care Specialists (FCS) Medical Incorporated.

Signature: _____ Date: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

_____

Signature of health care provider representative:

_____ Date: _____

Office Locations:

Highland Park	5823 York Blvd., Ste. 1, Los Angeles, CA 90042	Tel. (323) 255-1575	Fax: (323) 255-8139
Los Angeles	1701 Cesar E. Chavez Ave., Suite 230, Los Angeles, CA 90033	Tel. (323) 226-1101	Fax: (323) 226-1101
Los Angeles	1701 Cesar E. Chavez Ave., Suite 402, Los Angeles, CA 90033	Tel. (323) 317-9200	Fax: (323) 317-9206
Montebello	815 W. Washington Blvd., Montebello, CA 90640	Tel. (323) 728-3955	Fax: (323) 728-6905

Methods of Disclosure Authorization

Authorization for how Disclosures are to be made
Regarding Protected Health Information (PHI)

Name:_____ DOB:_____
Printed

HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of PHI. The individual is also provided the right to request confidential communications of PHI by made by alternate means, such as sending correspondence to the individuals' office or other place instead of home.

I wish to be contacted in the following manner (check all that apply):

Telephone

☐ Home _____ ☐ Mobile _____

☐ Ok to leave detailed message with person answering the phone or on my machine.

☐ Leave call-back information with person answering the phone or on my machine.

Written Communication

☐ Ok to mail to my home address

☐ Ok to e-mail me at: _____

☐ Ok to fax to this number_____

Alternative Contacts

I _____, hereby authorize Family Care Specialists (FCS) Medical Corporation to disclose Protected Health Information to the following individuals:

Name:_____ Relationship: _____Date of Birth_____

Home Phone: _____ ☐ leave call back information ☐ leave detail message

Name:_____ Relationship: _____Date of Birth _____

Home Phone: _____ ☐ leave call back information ☐ leave detail message

I understand that it is my responsibility to inform Family Care Specialists (FCS) Medical Corporation of any changes to this authorization.

Signature_____ Date _____