Raincross Medical Group, Inc.
4646 Brockton Avenue
Riverside, CA 92506
TELEPHONE (951) 774-2723

1. The following information is required for new patients and patients returning for Complete Physicals only.

2. Please check the box if you are experiencing any of the following symptoms:

☐ Fever	☐ Chills	☐ Wt loss	☐ Weakness	☐ Fatigue
☐ Blurred Vision	☐ Eye pain	☐ Double Vision	☐ Itchy Eyes	☐ Eye Discharge
☐ Earache	☐ Poor hearing	☐ Nasal Drainage	☐ Sore throat	☐ Post nasal drip
☐ Shortness of Breath	☐ Cough	☐ Colored Mucus	☐ Wheezing	☐ Chest tightness
☐ Chest pain/Pressure	☐ Palpitations	☐ Syncope	☐ Swelling	☐ Low Blood Pressure
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation	☐ Abdominal Pain
☐ Black stool	☐ Heartburn	☐ Bloody vomit	☐ Rectal Bleeding	☐ Change in Bowel habits
☐ Painful Urination	☐ Incontinence	☐ Night urination	☐ Frequency	☐ Urgency
☐*For Women	☐ Irregular Flow	☐ ↓Urine flow	☐ Vaginal discharge	☐ Itching
☐*For Men	☐ Hesitancy	☐ Urine Dribbling	☐ Erectile Dysfunction	☐ ↓ Libido
☐ Neck Pain	☐ Back pain	☐ Joint Pain	☐ Stiff joints	☐ Walking problems
☐ Skin Rash	☐ Itching	☐ Irregular moles	☐ Ulceration of skin	☐ Breast Pain/Discharge
☐ Headache	☐ Dizziness	☐ Seizures	☐ Vertigo	☐ Chronic Pain
☐ Appetite Changes	☐ High Blood Sugars	☐ Hunger	☐ Hot flashes	☐ Nose bleeds
☐ Easy Bruising	☐ Easy Bleeding	☐ Hives	☐ Food Allergies	☐ Blood Clots

Patient Name: (print) _____

Patient Signature: _____

Date: _____

Date of Birth: _____

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4646 Brockton Avenue
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FAX (951) 774-2817

PATIENT REGISTRATION

ACCOUNT # _____

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY #

DATE OF BIRTH MO DAY YR	AGE	SEX F or M	MARITAL STATUS M S D W C

HOME ADDRESS	CITY	ZIP	HOME PHONE

EMPLOYER	OCCUPATION	DRIVER'S LICENSE

WORK ADDRESS	CITY	ZIP	WORK PHONE EXT.

PERSONS FINANCIALLY RESPONSIBLE

LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY #

DATE OF BIRTH MO DAY YR	AGE	SEX F or M	MARITAL STATUS M S D W C

HOME ADDRESS	CITY	ZIP	HOME PHONE

EMPLOYER	OCCUPATION	DRIVER'S LICENSE

WORK ADDRESS	CITY	ZIP	WORK PHONE EXT.

1ST INSURANCE CO.

COMPANY'S ADDRESS	SUBSCRIBER'S NAME

ADDRESS	DATE OF BIRTH

	POLICY # AND GROUP #

2ND INSURANCE CO.

COMPANY'S ADDRESS	SUBSCRIBER'S NAME

ADDRESS	DATE OF BIRTH

	POLICY # AND GROUP #

OTHER INFORMATION

PERSON TO CONTACT FOR EMERGENCY	HOME PHONE

HOME ADDRESS	WORK PHONE EXT

NEAREST RELATIVE NOT LIVING WITH YOU	HOME PHONE

EMPLOYER	WORK PHONE EXT

REFERRED TO US BY:	

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Assignment of Benefits/Authorization

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the responsibility of the patient to pay any deductible amount, co-pay, co-insurance, or any other balance not paid for by insurance.

IN ORDER TO CONTROL THE COST OF BILLING, WE REQUEST THAT THE TOTAL CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including MediCare, private insurance, and other health plans to: Raincross Medical Group, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

ADDITIONAL CHARGES MAY BE BILLED FROM OTHER PROVIDERS FOR SERVICES RENDERED.

Signed _____ Date _____

CONSENT FOR TREATMENT

1. I voluntarily consent to such care including routine procedures and other treatment by Raincross Medical Group, Inc. professionals and their assistants, appointees, or consultants as is necessary in their judgement.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination by Raincross Medical Group, Inc.

3. I understand that for certain procedures deemed necessary by my physician I will be required to sign a Special Consent Form.

4. I understand that Raincross Medical Group, Inc. shall not be responsible or liable for the loss of/or damage to any personal property.

5. I authorize the release by telephone, mail, fax, computer or personal delivery to any party responsible for my care, such information from my records as is required in order for the clinic and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement is received.

PRINT

Patient name_____ Date of birth _____.

Signature of patient _____ Date_____

Signature of parent or guardian _____

Relationship _____

Signature of Witness _____

Raincross Medical Group

Carl Knopke, MD
Board Certified Family Medicine

Today's Date: _____ Date of visit (if different): _____

General History

Name:_____ DOB:_____ Age: _____
Home Address:_____
Contact Phone Number(s):_____ E-mail:_____
Sex: M F Wt:_____ Ht:_____ Marital Status: Married Single Divorced Widowed
Primary language: ☐English ☐Spanish ☐Other_____
Last or Current Occupation and when:_____
Past Medical History:_____
_____
_____
_____
Vaccinations-Last: Tetanus_____ Flu _____ Hepatitis B_____ Pneumovax_____
Tuberculosis Exposure ☐Yes ☐No ☐Maybe Recent travel_____ Last PPD & Result_____
Past Surgical History:_____
_____
Past Psychiatric History:_____
_____
Current Medications (including herbs): _____
_____
_____
Medication Allergies (and describe the allergic reaction):_____
_____
Family History – Chronic medical problems of your mom, dad, sister, and brother and age of onset:
_____
_____
Social History: With whom do you live:_____ Number of Children:_____
Smoking: Current Prior Never # of packs/day(avg):_____ and # of yrs smoked:_____ Quit Date_____
Alcohol – Please describe what, how much, and how often you drink:_____
_____
History of recreational drug use:_____
Do you have an advanced directive (for ages >= 18 years old)?:
☐Yes (Please leave a copy with our office) ☐No → ☐I want more information ☐I have no idea what this is ☐I don't want one

Women only: Date of last PAP_____ Ever abnormal? Y N Ever had colposcopy?_____
History of HPV (Human Papilloma Virus)?_____ Date of Last MMG_____ Ever abnormal MMG? Yes No
Last Menstrual period:_____ Age of onset Menses_____ Age of Menopause_____
Frequency of Cycle:_____ Number days of flow:_____ Current birth control method (include vasectomy):_____
Currently pregnant?: Yes No Maybe Times you have been pregnant:_____ Number of live births:_____
Miscarriages:_____ Number of Abortions – Medically Indicated:_____ Elective:_____

Comments:_____

I have reviewed the above and discussed any abnormalities with the patient.
Doctor's Signature X:_____ Chart #_____

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ELIGIBILITY GUARANTEE FORM

I, _____ hereby certify that I am eligible
Name of Patient/Member/or Guardian

for _____ _____ / _____ / _____
(Name of Insurance Plan) Month Day Year

through _____ _____
*Employer Name Name of Subscriber

I have chosen _____ to be my Medical Provider.
Medical Group/Physician

I understand that if the above is not true or if I am **not eligible** under the terms of my employers Medical and Hospital Subscriber Agreement, I am liable for all charges for services rendered. Also if the above is not true, I agree to pay in full for all services received within **30 days** of receiving a bill from the above noted Medical Group/Physician.

_____
Signature of Patient (or Guardian)

ELIGIBILITY VERIFIED BY:

_____ _____
Staff Member Date

_____ _____
Member Service Rep at (Insurance Plan) Date

Member ID Number: _____

* Not applicable for Senior Plans.

HIPAA 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. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & accountability act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice. These include activities such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, training of residents and medical students, conducting clinical research, recruiting patients for research studies and providing customer service (such as conducting an internal quality assessment review).

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request. Except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective and last revised as of February 18, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint you may contact:
The U.S. Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257 or 1-877-696-6775

Authorization to release information:

Do not release my information to anyone except as detailed in the HIPAA Notice of Privacy Practices.

Or,

I give permission to disclose medical information to the following:

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Patient Rights and Responsibilities

Rights

- To receive service in a reasonable period of time.
- To receive medically necessary service
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have your medical coverage explained to you.
- To participate in treatment decisions.
- To refuse treatment
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
- To request review of your medical record by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.

Responsibilities

- Having appropriate identification, insurance membership cards, coverage stickers, etc at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship or a minor being treated.
- Providing a list of person who may receive medical information about you, on your behalf, in an emergency.

I have read and understand the HIPAA Notice of Privacy Practices and Patient's Rights and Responsibilities as stated above. These policies may change from time to time. I may request a current copy of this form at any time. I also agree to release (or not release) information as per the Authorization to Release Information Section:

Patient Name:_____

Signatory's Relationship to Patient:_____

Signature:_____ Date:_____