SCKE Health

NAME _____ DATE OF BIRTH _____

PHONE _____ TODAY'S DATE _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU TAKE IN THE SPACE BELOW

PLEASE INCLUDE HERBAL AND OVER THE COUNTER MEDICATIONS

DRUG NAME/ DOSE (miliigrams, etc)/ HOW OFTEN (daily, twice daily,etc)	

PRIMARY CARE PHYSICIAN _____

ALLERGIES/MED ALLERGIES _____

MEDICAL HISTORY - Circle YES or NO

DIABETES	YES / NO
ABNORMAL BLOOD SUGARS	YES / NO
WEIGHT PROBLEMS	YES / NO
HIGH CHOLESTEROL	YES / NO
HIGH THYROID	YES / NO
LOW THYROID	YES / NO
THYROID NODULE/GOITER	YES / NO
OSTEOPOROSIS	YES / NO
FRACTURES	YES / NO
HIGH BLOOD CALCIUM	YES / NO
ADRENAL INSUFFICIENCY	YES / NO
LOW TESTOSTERONE	YES / NO
IRREGULAR MENSES	YES / NO
POLYCYSTIC OVARIAN SYNDROME	YES / NO
PITUITARY DISEASE	YES / NO
GROWTH HORMONE PROBLEMS	YES / NO
HIGH BLOOD PRESSURE	YES / NO
HEART ATTACK	YES / NO
ANGINA	YES / NO
STROKE/TIA	YES / NO
KIDNEY FAILURE/DIALYSIS	YES / NO
KIDNEY STONES	YES / NO
CANCER	YES / NO

OTHER MEDICAL CONDITIONS? LIST BELOW

_____

_____

HOSPITALIZATIONS - LIST DATES AND REASON:

_____

_____

SURGERIES - LIST BELOW

_____

_____

FAMILY HISTORY

LIST CONDITIONS THAT RUN IN THE FAMILY BELOW:

	CIRCLE ONE	AGE / MEDICAL CONDITIONS
FATHER	LIVING / DECEASED / UNKNOWN	
MOTHER	LIVING / DECEASED / UNKNOWN	
BROTHERS	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
SISTERS	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	
CHILDREN	LIVING / DECEASED / UNKNOWN	
	LIVING / DECEASED / UNKNOWN	

IF YES, WHAT KIND _____

SOCIAL HISTORY

DO YOU USE TOBACCO? YES / NO

IF YES, HOW MANY PACKS PER DAY: _____

IF NO, HAVE YOU EVER SMOKED? YES / NO

ALCOHOL USE: YES / NO **IF YES, HOW OFTEN** _____

DRUGS USE: YES / NO **IF YES, WHAT KIND(S)** _____

EXERCISE RARELY / SOMETIMES / REGULARLY **HOW OFTEN?** _____

MARITAL STATUS: MARRIED / SEPARATED / DIVORCED / WIDOWED / SINGLE

OCCUPATION: _____ **PREFERRED LANGUAGE:** _____

PREVENTATIVE HISTORY

DO YOU HAVE AN ADVANCE DIRECTIVE?	YES / NO	(SEE ATTACHED ADVANCE DIRECTIVE FORM FOR MORE INFO)
HAVE YOU HAD A COLONOSCOPY?	YES / NO	IF YES, WHEN _____
HAVE YOU HAD A MAMMOGRAM?	YES / NO	IF YES, WHEN _____
HAVE YOU HAD A DEXA SCAN?	YES / NO	IF YES, WHEN _____
HAVE YOU HAD A TETANUS SHOT?	YES / NO	IF YES, WHEN _____
HAVE YOU HAD A FLU SHOT?	YES / NO	IF YES, WHEN _____

SCKE Health

NAME: _____ DOB _____

REVIEW OF SYSTEMS

General (Constitutional)	
Weight change?	yes / no
Loss of appetite	yes / no
Nausea	yes / no
Vomiting	yes / no
Fever	yes / no
Night sweats	yes / no
Fatigue	yes / no
Chills	yes / no

Nephrology (Kidney)	
high blood pressure	yes / no
dialysis	yes / no
kidney stone	yes / no
kidney transplant	yes / no

Respiratory	
shortness of breath	yes / no
cough	yes / no
wheezing	yes / no
coughing blood	yes / no

Allergy	
runny nose	yes / no
scratchy throat	yes / no
itchy eyes	yes / no
sinus congestion	yes / no
seasonal allergies	yes / no

Urology	
difficulty urinating	yes / no
blood in urine	yes / no
urinary urgency	yes / no
frequent urination	yes / no
urinary incontinence	yes / no
recurrent UTI	yes / no

Dermatology	
Rash	yes / no
Change in color of moles	yes / no
wounds	yes / no
dry skin	yes / no

Endocrinology	
excessive thirst	yes / no
excesive urination	yes / no
cold intolerance	yes / no
heat intolerance	yes / no

Neurology	
headache	yes / no
tingling, numbness	yes / no
insomnia	yes / no
memory loss	yes / no
dizziness	yes / no
gait abnormality	yes / no

Ophalmology (Eye)	
drainage from the eyes	yes / no
blurring / loss of vision	yes / no
floaters	yes / no

Head and Neck	
hearing loss	yes / no
sore throat	yes / no
ringing in the ears	yes / no
trouble swallowing	yes / no
hoarseness	yes / no

Cardiology	
chest pain	yes / no
palpitations	yes / no
blood clots in legs or arms	yes / no
murmur	yes / no
leg pain with exercise	yes / no
leg swelling	yes / no
high cholesterol	yes / no

Gastrointestinal	
heartburn	yes / no
bloating	yes / no
abdominal pain	yes / no
diarrhea	yes / no
constipation	yes / no
blood in stool	yes / no

Musculoskeletal	
joint pain	yes / no
joint swelling	yes / no
mucsle aches	yes / no
sciatica	yes / no
gout	yes / no

Psychology	
depression	yes / no
high stress level	yes / no
sleep disturbances	yes / no
suicidal thoughts	yes / no
eating disorders	yes / no
alcohol abuse	yes / no
under psychiatric care?	yes / no

Male Reproductive	
difficulty with erection	yes / no
difficulty with ejaculation	yes / no
decreased sex drive	yes / no

Female Reproductive	
recurrent yeast infections	yes / no
painful intercourse	yes / no
"PMS"	yes / no
fertility trouble	yes / no
vaginal itching	yes / no
irregular periods	yes / no
breast pain / discharge	yes / no
last menstrual period	

OTHER SYMPTOMS:

_____

_____

PATIENT NAME:

_____

PATIENT SIGNATURE:

_____

DATE:

_____

SOURCE OF INFORMATION, IF OTHER THAN PATIENT

NAME/RELATION _____ **SIGNATURE** _____

REVIEWED BY: RC BC SP RB PK MY MH LN SM LM SI JJ AB YK KO JC NS

SCKE Health

Patient Name:		
Appointment Date:	**Time:**	**Provider:**
Mailing Address (include City, State, and zip):		

Home Phone:	**Cell Phone:**
OK to Leave a Message at:	**OK to release Medical Information to:**

Date of Birth:	**Social Security Number:**
Marital Status:	**Email Address:**

Primary Insurance:	**Subscriber Name:**
Address:	**Subscriber ID:**
Phone Number:	**Date of Birth:**
Group Name:	**Group Number:**

Secondary Insurance:	**Subscriber Name:**
Address:	**Subscriber ID:**
Phone Number:	**Date Of Birth:**

Employer Name:	**Work Number:**

Emergency Contact Name:	**Pharmacy Name:**
Emergency Contact Address:	**Pharmacy Address:**
Phone Number:	**Pharmacy Number:**

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to **SCKE for** all my insurance claims related to services received. I agree to pay all charges that exceed or are not covered by my insurance. I understand that co-pays, deductibles, and non-covered services are due at the time of service.

Signature of Responsible Party: _____ **Date:** _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ **Date:** _____

SCKE Health

Dear Patient

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***BEST POSSIBLE HEALTH*** requires a "partnership" between you and your doctor. As our "partner in health", we ask you to help us in the following ways:

- **Schedule Visits with My Doctor for Annual Wellness and Physical Exams and complete recommended health screenings at least once a year.**

  I will schedule regular visits with my doctor to discuss which regular health screenings are appropriate for my age, gender, personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, colonoscopy, etc.). These health screenings are tests that can help detect life-threatening diseases and conditions. If not completed, I put myself at risk of letting serious health problems go undetected.

- **Keep Follow-up Appointments and Reschedule Missed Appointments**

  I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition and/or continue to refill my prescriptions. **ALL CONTOLLED MEDICATIONS ARE CLOSELY MONITORED AND REQUIRE MORE FREQUENT FOLLOW-UP VISITS WITH THE PRESCRIBING PROVIDER. PLEASE PLAN ACCORDINGLY AS UNTIMELY FOLLOW-UPS WILL RESULT IN THE DENIAL OF REFILLS.**

- **Call the office When I Do Not Hear the Results of Labs and Other Tests**

  I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within 2 weeks, I will call the office or check my portal for test results and to message the doctor.

- **Inform My Doctor if I decide NOT to follow his or her Recommended Treatment plan**

  I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. **We are available for walk-ins and same day sick visits Monday-Saturday.**

Patient Name_____ **DOB**_____

Patient Signature_____ **Date**_____

SCKE Health

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND ADVANCE DIRECTIVES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices and information on Advance Directives. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed_____ Date_____

Printed Name_____ DOB_____ Telephone_____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

ESPANOL

Por la presente reconozco que he recibido una copia del Aviso de esta practica medica de practicas de privacidad and manifestacion anticipada de voluntad. Ademas, reconozco que una copia del aviso actual sera fijada en la zona de recepcion, y que una copia de la Notificacion de Practicas de Privacidad modificado estara disponible en cada cita.

Firmado_____ Fecha _____

Imprimir Nombre_____ DOB _____ Telefono_____

Si no esta firmada por el paciente, por favor indique la relacion:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y direccion del paciente_____

SCKE Health

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

For patients referred to South County Kidney and Endocrine Lab (SCKE Lab) by physicians practicing with SCKE Health Medical Group. California law (Business & Professions Code 654.2) requires that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred, so that you may address any concerns you may have directly with your physician.

Your referring physician is a member, owner, or employee of SCKE, Inc. which also owns South County Kidney and Endocrine Lab to which you have been referred for laboratory services.

Patient's Freedom of Choice. You are free to choose any doctor or organization you wish for obtaining services that may be ordered or requested for you by any of the doctors at SCKE Health. This choice, however, may be affected by restrictions imposed by your insurance plan. Your doctor would be happy to discuss alternative with you.

Potential sources of information concerning alternatives can also be obtained from the Yellow pages, the internet, or the county medical association.

By signing below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of this facility.

Printed Patient Name:_____

Patient Signature (or legal representative):_____

Date:_____

SCKE Health

OVERVIEW OF FINANCIAL RESPONSIBILITIES AND DISCLOSURES

SCKE Health Responsibilities: To submit claims to insurance carriers and statements to the patient/responsible party based on their information made available to us.

Patient/Parent/Guardian Responsibilities: To understand and manage benefits of their own individual plans. To assure that our office is provided with the most current information known about their insurance and to inform us of any changes to insurance, address, phone numbers, etc. To pay for copays at the time of service and remit, within 30 days, any balances due to our office for deductibles, co-insurance, or patient out-of-pocket portions.

PATIENT INFORMATION

Patient Name (First, Middle, Last)	**Patient Date of Birth**	**Date**
Insurance Subscriber Name	**Relationship to patient**	**Subscriber DOB**

SCKE Health Detailed Policies: Please READ and INITIAL EACH SECTION

☐ **Bring the patient's insurance card to every visit.** Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid active insurance cared will be considered self-pay and will be responsible for 100% of the medical services provided at the times of visit. Patients will have full responsibility for charges. If, we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately. Delays cause by patients can result in the claim being uncollectable from insurance, resulting in the patient having full responsibility for all charges.

☐ **Patient(s) must understand their OWN network, plan benefits, and plan limitations.** Your health insurance is an agreement between you and your insurance company. All charges are ultimately your responsibility. It is not possible for us to know specific details of your coverage because there are so many plans. By making a copy of your insurance card does not confirm that we are part of your insurance network. WE always do our best, but failure to identify out-of-network plans does not waive your responsibility for payment of rendered services. We recommend that you check with your insurance before services are rendered if you have any questions about coverage. We recommend that you check if your plans network includes our office by using our tax ID number (TIN) is 202278889, and what cost sharing may be applied.

☐ **We are in network with the Heritage Healthcare HMOs.** Our "home" networks are REGAL Medical Group and ADOC (Affiliated Doctors of OC). Patients seeing our specialists with an HMO assigned to the following IPAs: Memorial Care, Greater Newport, or Seoul MUST confirm that there is a valid authorization approved for EACH appointment when checking in. All unauthorized visits will be billed a service fee $150. **SCKE IS NOT IN NETWORK WITH: MONARCH, PROSPECT, MHAP (MISSION AFFILIATED), ST. JOSEPH'S OR OSCAR.**

☐ **All patients belonging to REGAL, ADOC, Memorial Care or Greater Newport IPA must utilize an outside lab.** Labs drawn at SCKE are considered out of network for these IPAs and will be billed directly to the patient.

☐ **SCKE lab is in-network with Medicare, Tricare, and most commercial PPO plans.** It is the patients' responsibility to verify with their individual insurance plans to confirm network participation.

☐ **All Procedures have fees, in addition to the visit fee.** It is not uncommon for insurances to apply ancillary services (ie labs and ultrasounds) to a patient's deductible first. Please check with your insurance since each plan is different.

☐ **Appointment cancellation fees.** We make numerous efforts to remind you of appointments. As a courtesy to other patients that need appointments, please notify us if you need to reschedule or cancel your appointment at least one business day prior. To encourage early notification. **A Fifty-dollar ($50.00) fee will be charged for same day cancellations or no-shows for all office visits and ultrasound appointments; this will not be covered by your insurance company.**

- **Due to the large block of physician time, equipment, and needed to perform biopsies, last minute cancellations can cause problems and added expenses for the office. If a biopsy is not cancelled at least 24 hours in advance you will be charged a $100.00 fee; this will not be covered by your insurance company.**

☐ **Account balances.** We will require that patients with self-pay balances pay off their account balances prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the billing company. Patients with balances greater than 90 days past due or over $100 must make payment arrangements prior to future appointments being made.

☐ **Bills are DUE UPON RECEIPT.** We are required to collect copay, deductible and co-insurance. Past due balances will be assessed a $10 statement fee for each additional statement we must send. Any self-pay, out of network, or other courtesy adjustments will be rescinded if account becomes over 30 days past due. WE may add a 18% interest charge or $50 late fees for delinquent payments past 90 days. We exhaust efforts to resolve balances prior to the use of a collection agency; at which time collection fees will be applied. Returned checks will be assessed a $35 fee.

☐ **Your health information is protected.** We must release patient health information to complete medical operations, e.g., to pharmacies, labs, insurance carriers, other physicians, etc. Any other release requires your written consent. Our Notice of Privacy Practices is made available to you upon request.

SCKE Health

I, _____ GIVE or DO NOT GIVE (circle one) SCKE permission to leave a detailed message on my home or cell phone pertaining to my health information.

I, _____GIVE SCKE permission to discuss/disclose my medical information to the following people:

Full Name_____Relationship_____phone_____

Full Name_____Relationship_____Phone_____

By signing below, I certify that I have read this financial policy and disclosures and understand its terms and conditions. I authorize the release of any medical information necessary to process my insurance claims, and request that payment of insurance benefits be made directly to SCKE. I also authorize the release of financial information to my account through direct phone calls and mailings as necessary to collect on all claim balances. I understand that I am responsible for my own bill if my insurance company does not pay. I further acknowledge, understand, and agree that if I fail to make such payments in accordance with the payment policies of the practice, or in the even of default of my financial obligation to pay for services rendered, the practice may terminate the "doctor-patient" relationship with the registered patient(s). Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

Signature of Patient/Responsible Person_____

Printed Name_____ Date_____