9471 Haven Ave #140
Rancho Cucamonga CA, 91730

PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME:_____LAST NAME:_____Middle Initial:_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone Number:_____Cell Number:_____Work:_____

Date of Birth:_____Gender: M F Race (Optional)_____SS#:_____

Preferred Language:_____Marital Status:_____E-mail Address: _____

EMERGENCY CONTACT

FIRST NAME:_____LAST NAME:_____

Home Phone Number:_____Cell Number:_____Work:_____

Relationship to patient:_____

RESPONSIBLE PARTY INFORMATION *(if different from patient)*

FIRST NAME:_____LAST NAME:_____Middle Initial:_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone Number:_____Cell Number:_____Work:_____

Date of Birth:_____Gender: M F Social Security #:_____Marital Status: _____

Relationship to patient: _____

INSURANCE POLICY HOLDER INFORMATION

Per Inland Endocrine Policy, patients must present insurance card and drivers license to be copied at intake.

Unfortunately, patients without valid insurance card and ID will not be checked in and will need to reschedule their initial appointment.

Lab Work and Forms

Any lab work not conducted in our clinic is sent out to a reference lab such as LabCorp, or Quest. The fees associated with these tests are ***in addition*** to your current charges with Inland Endocrine and will be billed separately to your insurance carrier as a courtesy by the lab; however, you are ultimately responsible for these charges and may receive a bill directly from the lab, for which you are responsible.

Patients who request healthcare-related or other forms/paperwork/ applications filled out or signed will be charged an additional fee.

Medication Refill Policy

It is the policy of Inland Endocrine that all patients should have their prescription refilled during their normally scheduled office visit. When this is not possible, any other medication refill requests should be made through your pharmacy 3-5 days before your medication will run out. The pharmacy will forward the necessary information to our office.

- Patients are required to give 3 business days' notice for prescriptions that need to be refilled.
- Inland Endocrine does not refill medications prescribed by other physicians, unless our practitioner first evaluates the patient.
- The patient is responsible for knowing when their medication(s) are getting low. If a medication is getting low, the patient should confirm that they have an appointment scheduled with our office before their medication will run out.
- Patients are not to request early refills of controlled medications that are overused, lost, or stolen.

Providers and Consent to Treat

I understand that Inland Endocrine employs midlevel providers (Nurse Practitioners and Physician Assistants) and consent to their involvement in my care.

I hereby request my physician, midlevel provider, and/or other health care providers or their designees, to perform medical examination, testing, treatment, and care as they may deem necessary and available to me during my office visit or outpatient procedure, including but not limited to tests, examinations, anesthetics, x-rays, medical and surgical treatments, and other prescribed procedures.

You have the right to discuss your treatment plan with your physician, including the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. All patients have the right to accept or refuse medical or surgical treatment.

By signing this document, I certify that I have read and fully understand the above statements and consent fully and voluntarily to be treated by Inland Endocrine.

Telehealth Consent

I consent to the use of Telehealth for the delivery of health care services. Telehealth includes telemedicine, and involves the use of audio, video, or other electronic communications to interact with me, consult with health care providers, and/or review my medical information for the purpose of diagnosis, therapy, follow-up, and/or education.

No Show and Body Fluid Exposure

Patients who miss their appointment without calling to notify us at least 24 hours in advance (no show) will be charged a $50.00 fee.

In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection during my office visit or outpatient procedure, I am giving my consent to be tested for HIV, at no cost to me, so the healthcare worker can be treated promptly. I authorize release of this information to the exposed healthcare worker and his/her healthcare provider.

Non-Traditional Treatments

Inland Endocrine is committed to improving the wellness of our patients through a combination of traditional medicine and non-traditional, lifestyle-improvement approaches to treatment and prevention of chronic diseases. A non-traditional approach should be used as a supplement and does not replace the need for conventional medical treatment. If patients choose an exclusively non-traditional approach to treatment, they do so at their own risk, and although Inland Endocrine will support their decisions, should not be held liable for outcomes.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this document, you acknowledge receipt of the Notice of Privacy Practices and Bill of Rights and Responsibilities from Inland Endocrine. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at https://inlandendocrine.com or on request from our staff.

Guarantee of Payment

IF SELF PAY (considered self pay if valid and active insurance is not presented at time of service)**:** I agree to pay for all services rendered in full at time of visit. I understand that no insurance company will be billed for my services today by Inland Endocrine. Any procedures or lab tests performed will require a separate fee beyond the standard office visit fee.

IF INSURANCE (considered insured if valid and active insurance is presented at time of service)**: Assignment of Benefits:** I authorize payment of benefits to Inland Endocrine for all services performed and billed by Inland Endocrine. I assign to Inland Endocrine all of my rights, benefits, interests, claims, remedies, causes of action, privileges, protections, and recoveries of any type whatsoever arising out of or related to any insurance source. **Release of Information:** I authorize the release of any medical, demographic, or other information necessary to process claims, for payment, treatment, or healthcare operations. I further understand that Inland Endocrine may be permitted or required to disclose health information to government agencies or other organizations for including but not limited to information about infectious diseases. **Other:** I acknowledge that I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and Inland Endocrine's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance. While Inland Endocrine makes every effort to verify my correct insurance information prior to leaving, I understand Inland Endocrine cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred. **My signature on these policies is herein on file for all billing claim forms.** I

authorize all insurance sources to pay Inland Endocrine directly for all services I receive. If I receive services not covered by an insurance source, then I agree to pay all charges for those services. If my account is referred to an attorney or collection agency, then I agree to pay actual collection costs, including attorney's fees and interest. If there is a credit balance on my account, I authorize Inland Endocrine to apply the credit balance to all unpaid services on my account (or my guarantor's accounts). I authorize Inland Endocrine to release my confidential medical information verbally, electronically, and/or in writing, to my insurance carrier, and other health care providers involved in my care, for purposes of treatment, payment of charges, quality assurance, utilization review, transfer, referrals, etc. I further authorize Inland Endocrine to download my medication history as prescribed by other providers, to become part of my medical record at Inland Endocrine.

Release For Family And Friends

If you wish to authorize Inland Endocrine to discuss or share your health information with family or friends, you must do so here:

I, THE PATIENT, HEREBY AUTHORIZE INLAND ENDOCRINE TO DISCUSS OR OTHERWISE RELEASE ANY OR ALL OF MY PERSONAL HEALTH INFORMATION OR MEDICAL RECORDS, WITHOUT EXCEPTION, INCLUDING DIAGNOSES, DIAGNOSTIC TEST RESULTS (INCLUDING LABS), OR ANY OTHER INFORMATION, BY PHONE, IN WRITING, IN PERSON, OR BY ANY OTHER REQUESTED MEANS, TO THESE FAMILY MEMBERS OR FRIENDS ONLY:

Name:_____

Address:_____

City/State/ZIP:_____

Phone:_____

Other form of contact:_____

Name:_____

Address:_____

City/State/ZIP:_____

Phone:_____

Other form of contact:_____

Informed Consent for Medical Services

I understand that various procedures may occasionally be recommended by my provider. These procedures may be relatively routine such as an injection of a medication or a more detailed procedure such as thyroid ultrasound, fine needle aspiration, etc. I understand that all procedures have some degree of risk associated with them, including the possibility of allergic reaction, vascular, nerve, tendon, or tissue damage, infection, scarring, rash, bleeding and under rare and unusual circumstances, disability or death. I understand the possibility of routine complications and side effects of any medication prescribed or administered either by injection or by mouth, given in the clinic or prescribed to be taken at home. I understand that there is no medicine that is entirely free of potential side effects which are usually mild but could potentially be severe, I accept the possibility of complications or even the chance of severe allergic reaction resulting in death. I accept the responsibility to discuss any concerns with my provider and the pharmacist. I will not take or accept any medication or procedure unless all of my concerns & questions have been addressed to my satisfaction. I will remind and make sure that my provider is aware of any allergies that I have, or past unacceptable side effects to medications or procedures and even the possibility of pregnancy.

Educational Consent

This facility is an educational facility participating in the training of student nurses and other health care personnel. I agree that they may participate in my care to the extend deemed appropriate by Inland Endocrine Staff.

Liability for Cost Share

I understand that, even if I have insurance from an insurance source, I am financially obligated to pay the copayments, co-insurance amounts, deductibles, and/or Medi-Cal Share of Cost (Cost Share), for the covered services provided by Inland Endocrine.

Contact Permissions:

Inland Endocrine may contact me (or leave message) to convey appointment, diagnostic, clinical, or any other healthcare information by:

_____ Home phone _____Cell Phone _____Work Phone _____E-mail address_____Mailing address

How Did You Hear About Us?

_____Insurance assigned me _____Billboard _____Internet Search _____Referred by family/friend

_____Social Media _____Other (please specify):_____

SIGNATURE

I certify that the information I have provided is complete and accurate to the best of my knowledge. I have also read, understand, and agree to all sections and pages of this Patient Registration / Intake packet, and my signature on this page effectively signs each of these sections, including, but not limited to:

- Guarantee of Payment
- Lab Work Policy
- Medical/Healthcare Form Filling Policy
- No Show Policy
- Medication Refill Policy
- Consent to Treat
- Healthcare Body Fluid Exposure
- Acknowledge of Receipt of Notice of Privacy Practices
- Record Release / Release for Family and Friends
- Contact Permissions
- Informed Consent for Medical Services
- Non-Traditional Treatments
- Patient Rights and Responsibilities

_____ _____

Signature *of Patient or Patient Representative* ***Date***

_____

Patient Name *(please print)*

_____

If Patient Representative*: Name of Patient Representative*

_____

If Patient Representative*: Relationship to Patient*