Rancho Santa Fe Medical Group
Dba, Mobile Doctor Medical Clinic
3230 Waring Ct. Ste. Q
Oceanside, CA 92056
Phone: 760-591-9975 - Fax: 760-591-9976

OFFICE POLICIES/PROCEDURES & FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Rancho Santa Fe Medical Group (RSFMG) Dba, Mobile Doctor Medical Clinic. We are committed to delivering excellent primary care. Please review our office and financial policies and procedures. We will be happy to answer any questions you have.

APPOINTMENTS:
I understand that appointments are pre-arranged and that it is my responsibility to keep my appointment or cancel my appointment with a minimum of 24 hours notice. If my appointment is missed or canceled with short notice, it deprives other patients the opportunity to be seen during that time. Missed appointments or failure to cancel an appointment with more than 24 hours notice with valid cause will result in a $25 change to my account.

BILLING/INSURANCE:
I Understand and agree that it is my responsibility to know my insurance coverage, including deductible, co-payments, co-insurances and prescription coverage, and how it applies to medical treatment in this office. Presenting my insurance care to this office does not guarantee payment by my insurance company. Regardless of my insurance status, I am ultimately responsible for the balance of my account and any medical services rendered. I understand that payment is due and payable at each visit. I understand that I am responsible for services not covered by my insurance company. There will be a $30 service fee for every check returned by the bank for non-sufficient funds, stop payments, etc. Statements or bills are due upon receipt, and a service fee of $10 will be added to any unpaid balance after 30 days past due. If it becomes necessary to refer my account to a collection agency, I will be responsible for all charges assessed by the collection agency in addition to the outstanding account balance.

RECORDS:
Records will be kept for seven years as per legal requirements. Copies of medical records can be transferred to other physicians upon receipt of written notification from the patients. Please provide the office with at least five business days notice when requesting records. I understand that there will be a minimum $20 fee for any medical records released for personal use. The fee may be higher depending on the amount involved or per page involved in transferring the records.

MISCELLANEOUS PATIENT REQUESTS:

I understand that here will be a fee for personal requests such as filling out forms, letters, financial reports, etc. Please ask our office for the fee schedule should you have a personal request.

MEDICATIONS:

Medication refills will be considered during office hours only. No refill requests will be handled after hours or on weekends. This is to conform to the California Pharny statutes and to allow for the maintenance of accurate records of medication consumption in the patient's chart for review by the State Pharmacy Review board if necessary. Patients should contact their pharmacy 1-2 days prior to the needed refill as the physician may not be immediately available the same day the medication runs out. Your provider will need 3 business days advance notice to pick up your WRITTEN prescription. Certain medications will not be refilled without a physical examination, and others will not be refilled after 3 months from the last date of service, i.e narcotics. No refills will be provided to any patient that has not been seen in this office in the last 6 months.

PATIENT RESPONSIBILITY:

Patient Consent: I hereby consent to and authorize the performance of medical treatment and any other surgical procedures which may be considered necessary or advisable by the attending physician or nurse practitioner. I also consent to and authorize any procedure or treatment to be documented with digital photography.

Financial Agreement: I hereby agree that I am financially responsible to the physician for all charges or any amount that is not paid or covered by insurance. It is the patients' responsibility that the bill is paid in full. We must emphasize that as your medical care provider, our relationship is with you and not your insurance company. We will try to make sure that your insurance claim will be filed on the same day or the next day following your visit. The filing of a medical insurance claim is an expensive process that we extend to you at no charge as a courtesy. However, we do ask that you pay all co-pays, deductibles, and non coerced changes the day of your service. All charges are your responsibility.

Assignment of insurance benefits/release of information: The physician may disclose all or any part of the patient record according to Health Insurance Portability & Accountability Act of 1996 (HIPAA)

I authorize my insurance company to pay benefits directly to the physician for services rendered.

I understand and agree with all the above office and financial policies and procedures and still want to receive professional medical services from Dr. Luis Navazo and RSFMG. All of my questions have been answered to my satisfaction.

By signing the Patient Information form, you acknowledge that you have read and understand the Office Policies and financial responsibilities.

Please retain this for your records.

Rancho Santa Fe Medical Group, Inc.
Mobile Doctor Medical Clinic
Patient Information Form

Today's Date _____/_____/_____

Name:_____ D.O.B. _____/_____/_____ Gender: Male ☐ Female ☐

Patient Address:_____

City:_____ST _____ Zip_____ SS #:___ ___ ___ - ___ ___ - ___ ___ ___ ___

Place of Service/Facility:_____ Provider Preference: Primary ☐ Podiatry ☐

Cell Phone:_____ Email:_____

Home:_____ Other:_____ Nursing Agency:_____

Referred By:_____ Nursing Agency #:_____

Referred Phone#:_____ Emergency Contact:_____

Conservator:_____ Emergency Contact Phone:_____

Conservator Phone #:_____ Relationship:_____

Patient Insurance Information

Primary Ins:_____ Policy #:_____

Secondary Ins.:_____ Policy #:_____

Cash Patient - YES ☐ Credit Card #:_____

Exp. Date:_____ Billing Zip:_____ 3 Digit Code on the back of the card:_____

Patient Responsibility

Patient Consent: I hereby consent to and authorize the performance of medical treatment and any other surgical procedures which may be considered necessary and advisable by the attending Provider. I also consent to and authorize any procedure or treatment to be documented with digital photography.

Financial Agreement: I hereby agree that I am financially responsible to the Provider for all charges or any amount that is not paid or covered by insurance. It is the patients' responsibility that the bill is paid in full. We must emphasize that , as your medical care provider, our relationship is with you and not your insurance company. We will try to make sure that your insurance claim will be filed on the same day or the next day following our visit. The filing of a medical insurance claim is an expensive process that we extend to you at no charge as a courtesy. However, we do as that you pay all co-pays, deductible, and non-covered charges the day of your service. All charges are your responsibility.

Assignment of insurance benefits/release of information: The Provider may disclose all or any part of the patient record according to Health Insurance Portability & Accountability Act of 1996 (HIPAA).

I Authorize my insurance company to pay benefits directly to the physician for services rendered.

Signature_____

Rancho Santa Fe Medical Group Inc.,
Dba Mobile Doctor Medical Clinic
3230 Waring Ct., Ste. Q
Oceanside, CA 92056
Phone: (760) 591-9975 - Fax: (760) 591-9976

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ HAVE RECEIVED A COPY OF
RANCHO SANTA FE MEDICAL GROUP, INC. dba MOBILE DOCTOR MEDICAL CLINIC
NOTICE OF PRIVACY PRACTICES.

_____ _____
Signature of Patient Date

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable**.

I have the right to revoke this consent, in writing, at any time, except to the extent that Rancho Santa Fe Medical Group, Inc. dba Mobile Doctor Medical Clinic & MD Portable has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, other health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

_____
Signature of Patient or Personal Representative

_____
Print Patient Name or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

HEALTH HISTORY FORMS

Welcome to our practice. As a new patient, please fill out the information below to the best of your ability.

Date:

Patient Name: _____ Date of Birth: ____/____/____

Chief Complaint: _____

History of present illness:

Location (where is the pain / problem?) _____

Quality (Example: color, activity, throbbing…) _____

Duration (when did it start) _____

Timing (Does the problem start at a specific time?) _____

Context (Where were you at the onset?) _____

Associated signs / symptoms / problems: _____

Modifying Factors (What makes it better or worse?) _____

Severity (Scale 1-10 with 10= most severe) _____

Past Medical History: Have you ever had any of the following?

□ Measles	□ Amenia	□ Back trouble	□ Hepatitis
□ Mumps	□ Bladder infection	□ High Blood Pressure	□ Ulcer
□ Chicken Pox	□ Epilepsy	□ Low Blood Pressure	□ Kidney Disease
□ Whooping cough	□ Migraine headache	□ Hemorrhoids	□ Thyroid Disease
□ Scarlet Fever	□ Stroke	□ Venereal Disease	□ Mitral Valve Prolapse
□ Diphtheria	□ Diabetes	□ Asthma	□ Arthritis
□ Smallpox	□ Cancer	□ Hives or Eczema	□ Bronchitis
□ Pneumonia	□ Polio	□ AIDS OR HIV +	□ Hernia
□ Rheumatic fever	□ Glaucoma	□ Infectious Mono	□ Heart disease
□ Tuberculosis	If checked, date of last chest X-ray: _____		
□ Bleeding tendency	If checked, blood or plasma transfusion - YES □ NO □		

Previous Hospitalizations, Surgeries, Serious Illness	When?	Hospital, City, State

Medications: (Include nonprescription)

Patient Social History

Marital Status: □ Single □ Married □ Seperated □ Divorced □ Widowed

Use of alcohol: □ Never □ Rarely □ Moderate □ Daily

Use of tobacco: □ Never □ previously, but quit □ Currently - ____ packs / day

Use of Drugs □ Never □ Current - Type / Frequency _____

Excessive exposure at work or home to:

□ Fumes □ Dust □ Solvents □ Noise □ Air-born Particles

Family Medical History

	Age	Diseases	If Deceased Cause of Death
Father			
Mother			
Siblings			
Children			

Review of Systems, Please indicate any personal history below:

Constitutional Symptoms:

Good General Health Lately	□ Yes □ No
Recent weight changes	□ Yes □ No
Fever	□ Yes □ No
Fatigue	□ Yes □ No
Headache	□ Yes □ No
Eye disease or injury	□ Yes □ No
Wear glasses / contacts	□ Yes □ No
Blurred or double vision	□ Yes □ No
Ear / Nose / Mouth / Throat	□ Yes □ No
Hearing loss or ringing	□ Yes □ No
Earaches or drainage	□ Yes □ No
Chronic sinusitis or Rhinitis	□ Yes □ No
Nose bleeds	□ Yes □ No
Mouth sores	□ Yes □ No
Bleeding gums	□ Yes □ No
Bad breath or bad taste	□ Yes □ No
Sore throat or voice changes	□ Yes □ No
Swollen glands in neck	□ Yes □ No

Cardiovascular:

Heart trouble	□ Yes □ No
Chest pain or angina pectoris	□ Yes □ No
Palpitation	□ Yes □ No
Shortness of breath	□ Yes □ No
Swelling of feet, hands…	□ Yes □ No

Respiratory:

Cough / Throat clearing	□ Yes □ No
Spitting up blood	□ Yes □ No
Shortness of breath	□ Yes □ No
Wheezing	□ Yes □ No

Gastrointestinal

Loss of appetite	□ Yes □ No
Change in bowel movements	□ Yes □ No
Nausea / Vomiting	□ Yes □ No
Frequent diarrhea	□ Yes □ No
Painful bowel movements	□ Yes □ No
Constipation	□ Yes □ No
Rectal bleeding / blood in stool	□ Yes □ No
Abdominal Pain	□ Yes □ No

Genitourinary:

Frequent urination	□ Yes □ No
Burning / painful urination	□ Yes □ No
Blood in urine	□ Yes □ No
Change in force of strain	□ Yes □ No
Incontinence / dribbling	□ Yes □ No
Kidney stone	□ Yes □ No
Sexual difficulty	□ Yes □ No
Male-testicle pain	□ Yes □ No
Female-pain with periods	□ Yes □ No
Female-irregular periods	□ Yes □ No
Female-vaginal discharge	□ Yes □ No
Female # of pregnancies	_____
Female # of miscarriage(s)	_____
Female-date of last PAP	_____

Musculoskeletal

Joint pain	□ Yes □ No
Joint stiffness	□ Yes □ No
Joint swelling	□ Yes □ No
Weakness of muscles	□ Yes □ No
Weakness of joints	□ Yes □ No
Muscle pain or cramps	□ Yes □ No
Back pain	□ Yes □ No
Cold extremities	□ Yes □ No
Difficulty in walking	□ Yes □ No

Integumentary / Skin / Breast

Rash or Itching	□ Yes □ No
Change in skin color	□ Yes □ No
Change in hair or nails	□ Yes □ No
Varicose veins	□ Yes □ No
Breast pain	□ Yes □ No
Breast lump	□ Yes □ No
Breast discharge	□ Yes □ No

Neurological

Frequent headaches	□ Yes □ No
Dizzy / light headed	□ Yes □ No
Convulsions / seizures	□ Yes □ No
Numbness / tingling	□ Yes □ No
Tremors	□ Yes □ No
Paralysis	□ Yes □ No
Head injury	□ Yes □ No

Psychiatric:

Memory loss	□ Yes □ No
Nervousness	□ Yes □ No
Depression	□ Yes □ No
Insomnia	□ Yes □ No
Suicidal thoughts	□ Yes □ No
Violent / unusual thoughts	□ Yes □ No

Endocrine

Glandular / hormone problem	□ Yes □ No
Excessive thirst urination	□ Yes □ No
Heat / cold intolerance	□ Yes □ No
Skin becoming dryer	□ Yes □ No
Change in hat or glove size	□ Yes □ No

Hematologic / Lymphatic

Slow to heal after cuts	□ Yes □ No
Bleeding / bruising tendency	□ Yes □ No
Anemia	□ Yes □ No
Phlebitis	□ Yes □ No
Past transfusion	□ Yes □ No
Enlarged glands	□ Yes □ No

Allergic / Immunologic

History of skin reaction or other adverse reactions to:

Penicillin / other antibiotics	□ Yes □ No
Morphine, Demoral / Narcotics	□ Yes □ No
Novocain / anesthetics	□ Yes □ No
Aspirin / pain remedies	□ Yes □ No
Tetanus antitoxin / serums	□ Yes □ No
Iodine / merthiolate / antiseptics	□ Yes □ No

Other /medications _____

_____

Food allergies _____

_____

Environmental allergies _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient Guardian: _____ Date: _____

Authorization for release of medical information

I hereby authorize Rancho Santa Fe Medical Group, Inc., dba Mobile Doctor Medical Clinic.
3230 Waring Court, Ste Q, Oceanside, CA 92056
Tel: (760) 591-9975 - Fax: (760) 591-9976

⬜ To Release Information to or ⬜Obtain information from:

Name: _____

Address: _____

_____

Tel: _____ Fax: _____

The Medical Records For:

Name: _____

Date of Birth: _____ Social Security #: _____

Disclosure is necessary for the purpose of _____ and that purpose only. I understand that this authorization extends to all of any part of the records information designated below, which may include treatment, physical and mental illness, alcohol or drug abuse, HIV/AIDS test results or diagnosis. The information to be released includes (please check records to be disclosed pursuant to this authorization):

☐ Complete Chart
☐ Treatment Plans
☐ Laboratory Data
☐ X-ray Data
☐ Discharge Summary
☐ Mental Status Exam
☐ Progress Notes
☐ Physicians Notes
☐ Medication List
☐ Other (Describe) _____
☐ Billing / Insurance info
☐ Verbal Discussion with
Name: _____
Relationship: _____

The treatment dates covered by this authorization are from pre admission to discharge and claims resolution. In any event, I may revoke this authorization at any time, except to the extent that action has been taken in reliance thereon. Authorization will automatically empire 60 days from the date or by y written request. I release Rancho Santa Fe Medical Group, Inc., dba Mobile Doctor Medical Clinic from all legal responsibility or liability that may arise from disclosure of medical records in reliance on this authorization. If the patient is a minor both the patient and the parent or guardian must sign the authorization. A facsimile or photocopy of this authorization may be in lieu of the original.

_____

Patient / Parent / Guardian signature Print Name Date

_____

Staff Member / Witness Signature Print Name Date

REVOCATION: I have the right to stop the release of information at any time. Although I do understand that RSFMG / Mobile Doctor cannot do anything about information already disclosed under this authorization; I no longer want any more information disclosed and I am revoking my authorization as of the date listed below.

Signature: _____ Date: _____