Holvik Family Health Center
221 E. Caldwell Ave. Visalia, Ca 93277
(559) 732-4726 Fax (559) 732-4747

PATIENT REGISTRATION FORM

Patient Name: (As Appears on Insurance Card)	Date:
Address:	Account:
City, State, Zip:	Date of Birth:

Sex: Male Female Marital Status:	Primary Phone #:
Email Address:	Cell Phone #:
Driver's License/ID #:	Work Phone#:
Employer:	Social Security #
Emergency Contact Name/Relation:	Phone #

PRIMARY INSURANCE: _____

Policy Holder Name:	
Policy Holder Date of Birth:	
ID or Subscriber #:	
Group #:	
Copay:	

SECONDARY INSURANCE:

Policy Holder Name:	
Policy Holder Date of Birth:	
ID or Subscriber #:	
Group #:	
Copay:	

I authorize the use of this information for the following purposes: to bill my insurance companies, to process my labwork and/or radiology, and to assist in my treatment with other healthcare professionals.

Signature_____ Date: _____

Holvik Family Health Center

HIPAA Waiver

A. Statement of Intent It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my Individually Identifiable Health Information to certain of my family and friends, regardless of my state of health. I am signing this authorization so my health care providers can disclose my health care information to the person(s) listed below, and openly discuss that information with them.

B. Authorization I, _____, hereby authorize my physicians, nurses, hospitals, and other health care providers to fully disclose my Individually Identifiable Health Information to any or all of the following authorized person (s):

Personal Representative: (Example Spouse, Parent, etc.)

Name (s) of
Representative: _____

Address: _____

_____ _____
Signature Date

Holvik Family Health Center

HIPAA Information and Consent Form

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully. The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. This form is a friendly version . A more complete text is available per your request and additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, hospitals, as is necessary and appropriate for your care. We specifically use electronic charts as our method of medical records. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI, and other documents and information.

2. Our office will call as a courtsey to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of normal value.

7. The practice agrees to provide the patient with access to their records in accordance with the state laws.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your PHI and to request changes in certain policies within the office concerning your PHI. However, the practice is under no obligation to alter internal policies to conform with your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in the office policy. I understand that this consent and acknowledgement shall remain in force indefinitely.

_____ _____

Signature Date

Holvik Family Health Center
Financial Waiver

Insurance: Always have your insurance card with you for all visits. If we ask for a current copy of your insurance ca and you do not have it, then you will be asked to reschedule.

a. It is the patients responsibility to verify change of PCP prior to your appointment (for all HMO insurances)
b. It is the patients responsibility to update any new insurance information in order for us to properly bill your insurance carrier
c. We DO NOT do any third party billing or treat Workers Comp
d. We are not accepting any new Medi-Cal or cash accounts
e. As a courtesy, our office will bill your insurance for you. You are responsible for the deductible, share of cost, and co-pay

DEDUCTIBLE: A deductible is the amount of expenses that must be paid out of pocket by the patient before your insurance will pay any expenses

CO-PAY: A co-pay is the fixed dollar amount that the patient pays for each office visit, and it is determined by the insurance plan.

a. All deductibles and co-pays are due at time of service, or you will be asked to reschedule
b. We DO NOT bill for deductibles or co-pays
c. If you are in between insurances, then we will temporarily collect cash for office visits. This amount must be paid a time of service

Balances: A balance may accrue for any services that are not covered by your insurance plan.

a. It is the patients responsibility to pay any remaining account balances
b. All outstanding balances are subject to a monthly finance charge of 5%
c. All balances that are more than 90 days past due will be sent to a collections agency, resulting in your dismissal from our practice
d. There is a $40 fee for all accounts sent to collections
e. Payment arrangements may be made with our billing department prior to being sent to collection agency
f. Our accountant requires that payment plans not be extended for more than 6 months

I authorize payment of medical benefits to be paid directly to the physician for services rendered. I authorize my physician to release any medical information that is necessary to process claims with my insurance companies.

I have read and accept the above. I agree to be responsible and pay for any unpaid charges and balances not covered by my insurance.

_____ _____ _____

Signature Date SSN #

If patient is a minor (under 18 years old), then the responsible party (parent or guardian) must sign above and complete the following information:

Name of responsible party_____ DOB_____

Relation to patient_____ SSN #_____

Holvik Family Health Center

Office Policy

1. Nurse Practitioners: A Nurse Practitioner is a registered nurse with special training for providing primary health care, including many tasks customarily performed by a physician. Physician Assistants: A Physician Assistant is a healthcare professional who is licensed to practice medicine as part of a team with physicians. Dr. Holvik has Nurse Practitioners and/or Physician Assistants that work jointly with him on our provider team. They assist him in seeing our patients, and many of your appointments will be scheduled with our Nurse Practitioners and Physician Assistants. All of our Nurse Practitioners and Physician Assistants have been thoroughly trained by Dr. Holvik. The Nurse Practitioners and Physician Assistants work closely with Dr. Holvik and discuss all matters with him as needed. Dr. Holvik has confidence in their ability as well as skills and assures you of exceptional medical care when you are scheduled with them.

2. Share of Cost: All deductibles and co pays are due at time of service. We DO NOT bill for co pays. You will be asked to reschedule if you are unable to pay for your deductible or co pay at time of service. All checks written are transmitted electronically. We accept cash, debit card, credit card, and personal checks as forms of payment. An appointment will not be able to be scheduled if there is balance on the account. Please contact our billing department if a payment needs to be paid. Our office DOES NOT accept Medi-Cal.

3. Missed Appointments: There is an $80 no-show fee for each missed appointment. Please let us know at least 24 hours in advance if you need to cancel or reschedule an appointment in order to avoid the $80 charge. If you need to cancel a Same Day appointment, we require a 2 hour notice in advance to avoid the $80 fee. Three no-shows will result in an automatic discharge from our practice.

4. Late Appointments: If you are late to your appointment, then you are also subject to an $80 fee and will be asked to reschedule your appointment.

5. Medication Refills: In order to expedite your prescription refills, we ask that you call your pharmacy directly with your request. You may also leave a message with our nursing staff; however, we do require 24-48 hours to contact your pharmacy with your request. If you receive a prescription during your office visit, we will send the prescription electronically to the pharmacy of your choice. A written prescription is also available per your request.

6. Triplicate Prescriptions: A prescription for a controlled substance (Percocet, Adderall, Methadone, etc) is also known as a Triplicate. There is a $10 fee for triplicate prescriptions, unless the prescription is received during an appointment.

7. Test Results: Please DO NOT call in for test results. We cannot discuss any test results over the phone. You may either schedule a follow-up appointment to discuss these results with one of the providers or you may request to pick up a copy of the results at the front desk.

8. Medical Records: If you would like to release or request your medical records to or from another doctor, then you must fill out a medical records release/request form available at the front desk. There is no fee for transferring records to another doctor or facility. However, if you would like a hard copy of your medical records for your own personal use, then there is a $25 fee.

9. Insurance: As a courtesy to you, our billing department will submit your medical claims to your insurance company. You are responsible for calling your insurance with any issues or questions pertaining to your insurance plan. Also, you must have your insurance card available at ALL appointments. You may be asked to reschedule if you are unable to present your insurance card. You are also responsible for updating any new insurance information.

10. Referrals: Most referrals take one week for authorization and scheduling for you. Please allow 7-10 business days before calling our office to check the status of a referral.

11. Form Fees: All forms filled out by the providers are subject to a $25 form fee, including EDD, FMLA, and DMV.

12. Courtesy: We ask that you are courteous of all staff members as well as other patients. We have zero tolerance for rudeness, profanity, or any other form of harassment. These actions can lead to dismissal from the practice.

13. Pet policy: Pets are not allowed in our office at any time.

14. Please be advised: If you have not been seen in the office for 3 or more years, you will be considered a new patient to the office. To maintain your patient care and active status please schedule your annual physical.

_____

Print Patient's Name

_____

Signature

_____

Date

Holvik Family Health Center
221 E. Caldwell Ave.
Visalia, CA 93277
Ph. 559-732-4726 Fax 559-732-4747

Request Medical Records

I request and give permission for the transfer of my medical records **Date:**

Name : **DOB:**

Address: **Phone:**

To: Holvik Family Health Center
221 E. Caldwell Ave Visalia CA 93277
Ph. 559-732-4726 Fax 559-732-4747

From: _____
Doctor or Facility Name

_____
Address

_____
Phone

_____
Fax

☐ All Records

-OR-

☐ Specific Records: _____

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).

-OR-

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental Health Records ☐ Alcohol/ Drug Abuse Treatment

☐ Communicable Diseases ☐ Other: _____

Signature: _____ Date: _____

This authorization is effective for up to one year after date signed by patient. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation.

Adult Health History Questionnaire:

Name_____ Date of birth_____

Address_____

Local phone number_____ Alternative phone number_____

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)_____

Special Communication Needs:		
Language preference:		
If 'yes' to any of the questions below, how can we assist?		
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	

Personal Health History

Please check past(P) or current(C) problems or conditions

P☐ C☐ Hypertension	P☐ C☐ Bowel/digestive problem
P☐ C☐ High cholesterol	P☐ C☐ Atrial Fibrillation
P☐ C☐ Diabetes	P☐ C☐ Seizures
P☐ C☐ Heart attack or angina	P☐ C☐ Headaches
P☐ C☐ Irregular heart rhythm	P☐ C☐ Stroke
P☐ C☐ Congestive heart failure	P☐ C☐ Prostate problem
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem
	P☐ C☐ Urinary tract infections
P☐ C☐ Pneumonia	P☐ C☐ Arthritis
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem
	P☐ C☐ Bleeding disorder
P☐ C☐ Asthma	P☐ C☐ Addiction Issues
P☐ C☐ Osteoporosis/Osteopenia	P☐ C☐ Depression
P☐ C☐ Cancer, Type:	P☐ C☐ Anxiety
P☐ C☐ Stomach ulcer	P☐ C☐ Mental Illness
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Other:
P☐ C☐ Liver Disease, Type:	

Previous Surgical Procedures

Please check if you have had any of the following

Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Other: _____	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner

Live here year round? ☐ Yes ☐ No If no, Part time location: _____

Occupation: **Concerns:** ☐ Stress ☐ Hazardous substances ☐ Heavy lifting

Tobacco use: ☐ Never ☐ Quit (when)_____ ☐ Current smoker: Packs/day, how many years_____

Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often_____

Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often_____

Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current

Describe:_____

Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period_____
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	**Pain, weakness, or numbness in**		Number of pregnancies _____
☐ Vomiting	☐ Arms ☐ Hips ☐ Back		Miscarriages_____
☐ Vomiting blood	☐ Legs ☐ Neck ☐ Shoulders		Birth control method _____
☐ Change in bowel habits	☐ Hands ☐ Feet ☐ Abdomen		Menopause ☐ Y ☐ N Age: _____

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: _____		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Last Occurrence
Tetanus vaccine / Tdap	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No	
Hepatitis ☐ A ☐ B	☐ Yes	☐ No	
Guardasil (HPV)	☐ Yes	☐ No	

Tests			Last Occurrence
Pap smear/pelvic	☐ Yes	☐ No	
Mammogram	☐ Yes	☐ No	
Bone Density	☐ Yes	☐ No	
Colonoscopy	☐ Yes	☐ No	
Prostate test	☐ Yes	☐ No	
Chest X-Ray	☐ Yes	☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: _____ **Phone:** _____ **Store #:** _____

Location Description:

Specialty Providers:	
In order that we can best coordinate your care, please list any medical providers you see outside of this practice	
Cardiologist Name: _____ Phone: _____ Last Seen: _____	**Nephrologist** Name: _____ Phone: _____ Last Seen: _____
Ophthalmologist Name: _____ Phone: _____ Last Seen: _____	**Psychiatrist/Psychologist** Name: _____ Phone: _____ Last Seen: _____
Oncologist Name: _____ Phone: _____ Last Seen: _____	**Allergist** Name: _____ Phone: _____ Last Seen: _____
Urologist Name: _____ Phone: _____ Last Seen: _____	**Gynecologist** Name: _____ Phone: _____ Last Seen: _____
Gastroenterologist Name: _____ Phone: _____ Last Seen: _____	**Pulmonologist** Name: _____ Phone: _____ Last Seen: _____
Endocrinologist Name: _____ Phone: _____ Last Seen: _____	**Podiatrist:** _____ Name: _____ Phone: _____ Last Seen: _____
Other: _____ Name: _____ Phone: _____ Last Seen: _____	**Other:** _____ Name: _____ Phone: _____ Last Seen: _____

Patient/Guardian Signature: _____ Date: _____

Holvik Family Health Center

Health Questionnaire

Name: _____ D.O.B.:_____

The confidential answers you give on this form will provide important background information for your doctor. Feel free to discuss any questions with the doctor. Please answer all questions to the best of your recollection.

Medical History

Past Medical Problems (examples: measles, chicken pox, hepatitis, pneumonia, heart attack, stroke, etc.)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Current Medical Problems: (examples: asthma, diabetes, high blood pressure, headaches, cancer, AIDS, etc.)

1._____ 4._____
2._____ 5._____
3._____ 6._____

Operations: (examples: appendectomy, c-section, gallbladder, Hysterectomy, tonsillectomy, etc.)	Dates	Serious Injuries: (examples: auto accident, hernia, fractures, wounds, head injuries, etc.)	Dates

Hospitalizations:

Name: _____ D.O.B.:_____

Name of Current Pharmacy: _____ **Location:** _____

Medications: List all medication you currently take. (include prescription medications, vitamins, aspirin, over the counter medication, cold remedies, birth control pill, etc)

Allergies to Medications	**Reactions**

Health Habits	**Yes**	**No**	**How much per day**
Do you drink alcohol?			
Do you smoke or use tobacco?			Quit when:
Do you use caffeine?			
Do you use illegal drugs?			Type: Amount:

What type of exercise do you get? _____

Menstrual History (Women only): Age of first menstrual period _____ Number of Pregnancies _____
Number of Children _____

Marital Status: Single _____ Married _____ Widower _____ Separated _____ Divorced _____

Occupation: _____ Employed: Yes No Student: Yes No Retired: Yes No

Highest level of education: _____ Hobbies: _____

Family History
List all immediate family members

	Living	Deceased	Age	List major medical problems and things that run in the family
Father				
Mother				