SEASIDE MEDICAL GROUP
OF TRI-CITY

Today's Date: ______________________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

LEGAL PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	**ADDRESS (please include apartment/unit number, if any)**		
CITY, STATE, ZIP	**PREFERRED CONTACT METHOD:**	**CELL PHONE**	**HOME PHONE**

BIRTH DATE	**SSN**	**SEX:** ❑ **MALE** ❑ **FEMALE**	**EMAIL**
ETHNICITY ❑ HISPANIC or LATINO ❑ NON-HISPANIC or LATINO	**RACE** ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White or Caucasian ❑ Two or More Races ❑ Decline to Specify ❑ Other ____________________	**PRIMARY LANGUAGE:** **EMPLOYMENT STATUS:** ❑ EMPLOYED ❑ RETIRED ❑ UNEMPLOYED ❑ DISBALED ❑ STUDENT	**LEGAL MARITAL STATUS:** ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED **SEXUAL ORIENTATION:** ❑ HETEROSEXUAL ❑ HOMOSEXUAL ❑ BISEXUAL ❑ OTHER

INSURANCE / RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE	**ID NUMBER**		**GROUP NUMBER**
SUBSCRIBER'S NAME	**RELATIONSHIP TO PATIENT:** ❑ SELF ❑ SPOUSE ❑ PARENT	**SSN**	**BIRTH DATE**
SECONDARY INSURANCE	**ID NUMBER**		**GROUP NUMBER**
SUBSCRIBER'S NAME	**RELATIONSHIP TO PATIENT:** ❑ SELF ❑ SPOUSE ❑ PARENT	**SSN**	**BIRTH DATE**

IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP TO PATIENT**	**PHONE NUMBER**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Seaside Medical Group of Tri-City and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PRINT NAME OF PATIENT	**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**	**DATE**

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect unless I provide a written notice of revocation to the Medical Record Department.

PRINT NAME OF PATIENT	**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**	**DATE**

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**

DO YOU HAVE AN ADVANCED CARE DIRECTIVE?❑ YES ❑ NO ❑ DECLINE

How did you hear about us? ❑Web search ❑ Family/Friends ❑ Insurance Directory
❑ Other: ______________________________

SEASIDE MEDICAL GROUP
OF TRI-CITY

Today's Date: ______________________

Medical History Questionnaire

Today's Date:	Legal Name: Last First Middle

Please tell us the reason(s) for your visit:

____

List any known allergies:

Reaction:	Reaction:
Reaction:	Reaction:

Preferred Pharmacy: (Please include Name, Address, and Phone)

____

List all medication(s) you are currently taking, including non-prescription, herbal products, supplements, ointments, injections, inhalers:

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Name: ______________________ **Dosage:** __________ **Frequency:**____________ **Taking as directed by physician Y/N** _____

Medical History: Have you ever suffered from any of the following?

- ❑ Heartburn/Reflux
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Pain
- ❑ Bladder Infection –UTI
- ❑ Bleeding Tendency
- ❑ Bronchitis
- ❑ Cancer
- ❑ Gallstones
- ❑ Depression
- ❑ Diabetes
- ❑ Liver Disease
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Disease
- ❑ Frequent Sinus Infections
- ❑ Hepatitis
- ❑ Osteoporosis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Prostate Enlargement
- ❑ Kidney Stones
- ❑ Kidney Disease
- ❑ Low Blood Pressure
- ❑ Crohn's/Colitis
- ❑ Migraine Headaches
- ❑ Mitral Valve Prolapse
- ❑ STD's, If so ____________
- ❑ Pneumonia
- ❑ Head Injury
- ❑ Psychiatric Disorder
- ❑ Thyroid Disorder
- ❑ Stroke
- ❑ Shortness of Breath
- ❑ Seizures
- ❑ Blood in the Stool
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Painful/Swollen Joints
- ❑ None of the problems listed

Family Medical History (Check all that apply)

	No Known Problems	Cancer	Diabetes	Heart Disease	Hypertension	Psychiatry	Stroke	Thyroid	Other
Mother									
Father									
Daughter									
Son									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Sister									
Brother									

Prior Surgeries (type and year

____
____
____

Prior Hospitalizations (reason and year)

____
____
____

General Health Maintenance

Skin test within the last 12 months? ____________ **Eye test in the last 12 months?** __________
Last colon cancer screening date and result: ______________________________
Last cholesterol blood work? ______________ **If over 65, Last DEXA (bone density) screening?** ______________
Pneumonia vaccine? _______ **If yes, when?** ________ **Flu vaccine?** _______ **If yes, when?** ______________
Did you receive the COVID-19 vaccine? ________ **If yes, which vaccine and when?** ______________________
Have you had any COVID-19 symptoms recently? ______________________________
Do you exercise? _________ **If yes, how often?** ______________________________
Have you traveled recently? __________ **If yes, where?** ______________________________
Do you have any pets? ______________________________
Have you recently fallen? ______________________________

Personal Sexual Activity

Sexually Active:	☐Yes	☐Not Currently	☐Never			
Birth-control / Protection:	☐Condom	☐Pill	☐Diaphragm	☐IUD	☐Surgical	☐Spermicide
	☐Implant	☐Rhythm	☐Injection	☐Sponge	☐Inserts	☐Abstinence
Partners:	☐Male	☐Female				

Do you use any of the following substances?

Substance	Current User?	Former User?	How often?	How Long? (years)	If stopped, when? (year)
TOBACCO	❑ Yes ❑ No	❑ Yes ❑ No			
ALCOHOL	❑ Yes ❑ No	❑ Yes ❑ No			
ILLICIT DRUGS	❑ Yes ❑ No	❑ Yes ❑ No			

Types: ❑ Marijuana ❑ Meth ❑ Cocaine ❑ Heroin ❑ Ecstasy ❑ LSD ❑ Other:________

Gynecological/Obstetrical History

Name of OB/GYN (Please Print): ______________________________
Age when you started menstruating: ____________ Number of pregnancies: ________________
Number of births: ________________ ☐Vaginal ☐C-Section
Date of last Pap smear: ________________ History of abnormal Pap smears? ☐Yes ☐No
Date of last Mammogram: ________________ History of abnormal Mammograms? ☐Yes ☐No
Menstrual Cycles? ☐Regular ☐Irregular Painful Periods? ☐Yes ☐No
Method of Contraception: ____________________ Age at menopause: ______________

I have entered all information to the best of my knowledge and verify that the information listed is accurate and true.

Financial Policy: Payment in full or co-payment is to be expected at time of service. Services that are not a covered benefit of your health plan will be your responsibility.

Consent to Treatment/Release of Information: I grant Seaside Medical Group of Tri-City permission to administer medical treatment and perform medical procedures as deemed necessary. I authorize the release of medical information to my insurer/insurer's agents to process my payments for service.

Assignment of Benefits: I thereby assign all benefits payable by my insurance company to Seaside Medical Group of Tri-City.

____
Print Name of Patient

____
Signature of Patient

____
Date

SEASIDE MEDICAL GROUP
OF TRI-CITY

Today's Date: ______________________

Financial Policy

Thank you for choosing Seaside Medical Group of Tri-City as your healthcare provider. The following is a statement of our financial policy. This financial policy applies to all services provided by our office.

Insurance Coverage – We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility, and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Copays – We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. Our office does not bill copays. **Copays are the patient's responsibility and are due at the time of service.** We are considered primary care by insurance carriers. If your insurance carrier has a specific copay amount for care, you will be expected to pay this amount at the time of service. We cannot waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

Laboratory Bills – Depending on your health plan laboratory procedures that are ordered during your visit will be billed to you directly by the laboratory. Please contact your laboratory directly for any questions regarding your lab bill.

For our patients with no Medical Insurance Benefits – If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. Please let us know if you are having difficulty paying your account as we may be able to help by setting up a payment plan based of your financial needs.

Accepted Forms of Payment – We accept payment by cash, check, Visa, MasterCard, and most other credit cards.

Missed Appointments- Please note a $25.00 cancellation fee will apply for missed appointments or failure to cancel within 24 hours prior to your scheduled appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Unpaid Accounts – In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Returned Check Fee – It is the policy of our office to charge $10.00 to patients whose checks are returned by our bank for nonsufficient funds.

I have read, understood and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim, and payment of medical benefit is to be paid directly to Seaside Medical Group for all services rendered.

______________________	______________________	__________
Signature of Patient	**Patient Name (Please Print)**	**Date**

SEASIDE MEDICAL GROUP
OF TRI-CITY

Today's Date: ____________________

Authorization to Obtain or Release Medical Records from Medical Providers

I hereby authorize Seaside Medical Group to obtain any and all medical records concerning my care from any physician, hospital, or other healthcare professional that has provided medical care to me in the past.

I also authorize Seaside Medical Group to release any and all medical records concerning my care to any physician, hospital, or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third-party administrator, or managed care company.

____________________ ____________________
Patient Signature **Date Signed**

____________________ ____________________
Printed Name **Date of Birth**

Authorization to Release Medical Information to Individuals/Family Members

In accordance with the federal governments privacy rule implementation of the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of Seaside Medical Group to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorizations prior to doing so. In the event of a critical episode, or if you're unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

A reasonable fee may be charges for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

______ I do not authorize the practice to release any information concerning my medical care to any individual except as set forth above.

______ I authorize the practice to release any and all information concerning my medical care to the following individual(s):

Name	Relationship to Patient	Phone Number

____________________ ____________________
Patient Signature Date

SEASIDE MEDICAL GROUP
OF TRI-CITY

Today's Date: ______________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by State and Federal laws to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

If you have any questions about his notice or you would like to request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: We use medical information about you to provide your medical care. We may disclose your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, medical review, legal services and audits, and to operate this medical practice. We have written contracts with each of these business associates and subcontractors that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased we may disclose PHI to a family member or individual involved in care or payment prior to death. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. We may charge a reasonable, cost based fee.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. You have the right to request restrictions on certain uses and disclosures of your health information by written request specifying that information you want to limit, and what limitations on our use or disclosure of that information

Non-routine Disclosures: You have the right to request a list of non-routine disclosures we have made of your health care information. We will include all disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make) going back 6 years.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family

member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Sale of PHI: We will not disclose PHI without your prior written authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law.

Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you maintain the right to request that copies of your health information be transferred to another physician or medical group.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your appointments, recommended services, or treatments. If you are not available, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign-in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our office for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If a copy is requested, we may charge a reasonable and cost-based fee. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a

readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Changes to this Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted at our reception desk and a copy will be available at each appointment.

QUESTIONS AND COMPLAINTS

Questions or complaints about this Notice of Privacy Practices or how this medical clinic handles your health information should be directed to our privacy officer below. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to U.S. Department of Health & Human Services.

HOW TO CONTACT US:

Practice Name: Seaside Medical Group of Tri-City

Privacy Officer: Sena Ghebre

Telephone: (760) 330-5055

Fax: (760) 542-2026

Address: 115 N El Camino Real Ste A

City, State: Oceanside, CA 92058