Salinas Valley Medical Clinic

PRIMECARE

Dear Valued Patient,

Welcome to Salinas Valley Medical Clinic PrimeCare and thank you for choosing us as your provider for primary medical care. Salinas Valley Medical Clinic PrimeCare follows the Patient-Centered Medical Home model of care, which transforms the way primary care services are conveyed, focusing on prevention and wellness. This model follows a team-based approach with a care team that is committed to keeping you healthy.

Being part of a Patient-Centered Medical Home comes with many additions which include coordinated care, patient-centered with you being a responsible contributor, accessible services, as well as safety and quality improvement. As your medical home, we request you provide your current medication list, regular updates to your medical history, update us with any changes in your health status, inform us of recent test results, and update us on any recent hospitalizations, specialty care, or emergency department visits.

As a medical home, providing accessible services is very important to us. Our practice follows open scheduling by reserving time for same day appointments. When calling for a same day appointment after 3pm, we may not be able to accommodate you but can schedule an appointment the following day or refer you to one of our urgent care clinics. We make every effort to accommodate requests for routine visits within one month.

At any time, during or after business hours, you may contact our office and receive clinical advice. When calling after business hours, your call will be answered by a live person at our answering service who will put you in touch with the provider on-call. In addition, Salinas Valley Medical Clinic PrimeCare has developed a relationship with Doctors on Duty Urgent Care to provide hands on care for our patients after normal business hours.

We have enclosed within this packet Patient Registration and Medical History forms. Please complete these documents and bring them with you to your appointment. If you are transferring to our office from another provider, please ask your provider to either mail or fax your current medical records to our office prior to your visit. Also, bring all your current medications so we can record this information in your file. If you have either an Advance Care Directive or Power of Attorney for Health Care, please bring copies of these with you at the time of your visit.

Salinas Valley Medical Clinic offers MyChart, which provides online access to your medical record. With MyChart you can manage many of your health information needs from home. You can access your medical record, schedule your next primary care appointment, request a prescription refill, access your test results, pay bills and view account statements online. It's free, secure and easy to use. For mobile users, the MyChart app is available on iOS and Android devices. At your doctor's visit you'll get instructions for how to sign up for MyChart.

We look forward to meeting you and providing you with the highest quality medical care and service.

Sincerely,

Salinas Valley Medical Clinic PrimeCare

Salinas Valley Medical Clinic
PRIMECARE

CAIR California Immunization Registry

IMMUNIZATION REGISTRY NOTICE TO PATIENTS AND PARENTS (TB)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an immunization registry to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the California Immunization Registry.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want yours or your child's records shared with other CAIR users, do nothing. You're all done.

If you DO NOT want yours or your child's records shared with other CAIR users, check with your provider to see if they send your sharing status to CAIR electronically. If they do not send, go to the CAIR Forms page (http://cairweb.org/cair-forms/) and complete a Request to Lock My CAIR Record. Locked records in CAIR can also be unlocked by completing the Request to Unlock My CAIR Record. Fax printed forms by email to 1-888-436-8320, CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

By law, public health officials can also look at the registry in the case of a public health emergency.

California Department of Public Health: Med Office IZ Registry Disclosure Letter rev 02/19 **IMM-891 E/S**

Thank you for choosing Salinas Valley Medical Clinic as your health care provider. Your treatment and successful recovery are our first priorities. In order to offer you the best possible service, we are providing information regarding our billing policies. Please read this information and sign below before any care is administered.

As a courtesy to you, we will bill your insurance carrier(s). We require that insurance cards be presented prior to/at the time of service and we will verify coverage. This includes authorizations by your insurance carrier, as needed. If your insurance carrier shows we are a participating provider, or where we accept assignment of benefits all co-pays, co-insurance, and deductibles are due at the time of service. This includes amounts due for "high deductible" plans as well as amounts due for "limited coverage" plans. Please keep in mind that participating providers may change from time to time and it is the responsibility of the patient to verify whether or not the physician you are seeing is listed as a participating provider with your specific insurance carrier.

Insurance coverage is an agreement between you and your insurance carrier. It is your responsibility to remit payment for charges not covered by your insurance unless your carrier clearly states in writing that you are not responsible. If there is a question about whether or not your insurance will cover a specific service, we may ask you to sign a financial waiver before that service is provided. If your claim is not cleared or paid by your insurance carrier within 45 days of billing, you will be required to remit payment to cover any outstanding balance.

A billing statement will be mailed to you after insurance claims have been processed. You will be billed for any remaining amounts that your insurance carrier indicates are patient responsibility. Payment is due upon receipt of our statement. If we do not receive payment or communication from you about any remaining balance in a timely manner, we reserve the right to send overdue accounts to collection.

I understand that Salinas Valley Medical Clinic is required to report (or code) procedures and diagnosis based on the services I receive; consequently, the coding cannot be changed later to cause the insurance company to pay for a non-covered service as this is considered fraudulent practice.

If your insurance carrier shows we are not a participating provider, or if you do not have insurance, please be prepared to pay your bill in full at the time of service. However, Salinas Valley Medical Clinic will courtesy bill your insurance carrier for you. In most cases, any reimbursement will be sent directly to you by your insurance carrier. If your insurance coverage changes, please send a copy of both the front and back of your new insurance card to our office so we can update your record. Patients will need to update their Patient Information Sheet at least annually.

Other Fees:
A fee of $25.00 for the completion of medical forms such as those required by DMV, PG&E, California State Disability, FMLA, etc. is due when picking up the completed forms. Please allow 7 business days to complete the forms. A fee is applicable to obtain a copy of medical records and is due when picking up those records. Please allow 3 business days to prepare the records. A list of fees can be obtained with the receptionist. The fee is not applicable when the records are subpoenaed by the court or are required by another physician for the purpose of the coordination of your healthcare. A fee of $25.00 for a checked returned for Non-Sufficient funds will be charged to your patient account.

Minor Patients:
The parent(s)/guardian(s) accompanying a minor is/are responsible for full payment. For unaccompanied minors, non-emergency service may be denied.

We accept cash, checks, Health Saving Account debit cards, and most major credit cards. If you have questions regarding our billing/payment policy or need assistance, please contact our billing office (Cypress Healthcare Partners) at (831) 649-1000. They may be able to set up a payment plan for you, if needed. I understand and agree to the above policy and I am the person responsible for payment of services rendered by Salinas Valley Medical Clinic.

Salinas Valley Medical Clinic
PRIMECARE

PATIENT REGISTRATION

By initialing in this box [ ] I am requesting Salinas Valley Medical Clinic not leave me a detailed/confidential message about my health or payment of my healthcare at the phone number listed here _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle: _____

Birthdate: ____/____/____ Gender: ❑ Male ❑ Female Social Security #: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other: _____

Home Phone: (____) _____ Work Phone: (____)_____ Cell Phone: (____) _____

E-mail Address: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Race: ❑ White ❑ African American ❑ Hispanic ❑ Other ❑ Declined

Ethnic Group: ❑ Non-Hispanic ❑ Hispanic ❑ Declined

PREFERRED METHOD OF CONTACT:

❑ **Phone** ❑ **U.S. Mail** ❑ **Email** By providing my cell phone number, I consent to Salinas Valley Medical Clinic - PrimeCare, including its business associates, calling and/or texting regarding appointments and to call regarding my care and/or payment of my care. Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws

IF PATIENT IS A MINOR PLEASE COMPLETE:

Name of Parent/Guardian: _____ Guarantor Date of Birth: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured: _____ Date of Birth: _____ Social Security #: _____

Relationship to Insured: _____ Insurance Address: _____

City: _____ State: _____ Zip: _____

Insurance Carrier Name: _____ Policy/Group #: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name (Not in Same Household): _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Relationship to Patient: _____

SURROGATE DECISION MAKER

Name: _____ Home Phone: _____ Relationship to Patient: _____

Do you have a Legal Durable Power of Attorney? ❑ Yes ❑ No

If yes, Name: _____ Phone: _____ Relationship: _____

Please provide a copy of the legal paperwork for your medical file.

PREFERRED PHARMACY

_____

PREFERRED LABORATORY

_____

I identify the following individuals as being involved in my care and /or payment of my care. I authorize my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Date of Birth: _____ Restrictions: _____ (i.e. medical info only, financial info only) Date of Birth: _____ Restrictions: _____ (i.e. medical info only, financial info only)

TO OUR PATIENTS:

This authorization will remain in effect until you revoke or modify it in writing. Any persons not listed above will not be given access to your personal information unless you personally call and give verbal consent. By your signature below, you acknowledge that you understand and agree to the above information.

Signature of Patient: _____ Date: _____

Please describe your illness/injury/symptoms and date of onset:

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____

ALLERGIES OR REACTIONS TO MEDICATIONS / FOODS / OTHER AGENTS:

ALLERGIC TO	REACTION OR SIDE EFFECT

❑ No Know Drug Allergies

MEDICATIONS: Prescription and non-prescription medicines, vitamins, and birth control pills:
Please provide your physician and/or medical assistant with a medication list if you have one.

MEDICATION	DOSE (Times per day)	TIMES PER DAY (Sig)

❑ Not currently taking medications

PAST MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems:

Cardiovascular
- ❑ congestive heart failure
- ❑ coronary artery disease
- ❑ hyperlipidemia
- ❑ hypertension
- ❑ peripheral vascular disease
- ❑ Other: _____

Pulmonary
- ❑ asthma
- ❑ chronic bronchitis
- ❑ COPD
- ❑ sleep apnea
- ❑ other: _____

Gastrointestinal
- ❑ cirrhosis
- ❑ crohn's disease
- ❑ hepatitis
- ❑ irritable bowel syndrome
- ❑ pancreatitis
- ❑ other: _____

Renal
- ❑ endometriosis
- ❑ infertility
- ❑ renal stones
- ❑ urinary incontinence
- ❑ urinary tract infection
- ❑ other: _____

Musculoskeletal
- ❑ chronic pain
- ❑ fibromyalgia
- ❑ fracture(s)
- ❑ gout
- ❑ osteoporosis
- ❑ rheumatoid arthritis
- ❑ other: _____

Endocrine
- ❑ diabetes, type 1
- ❑ diabetes, type 2
- ❑ hyperthyroidism
- ❑ hypothyroidism
- ❑ other: _____

Neurological
- ❑ alzheimer's disease
- ❑ attention deficit disorder
- ❑ ADHD
- ❑ cerebral palsy
- ❑ headaches, migraine
- ❑ multiple sclerosis
- ❑ seizures disorder
- ❑ other: _____

Hematologic
- ❑ iron deficiency anemia
- ❑ myelofibrosis
- ❑ other: _____

Allergy/ Dermatology
- ❑ allergies
- ❑ eczema
- ❑ psoriasis
- ❑ sinusitis
- ❑ other: _____

Cancers
- ❑ breast cancer
- ❑ colon cancer
- ❑ lung cancer
- ❑ melanoma
- ❑ ovarian cancer
- ❑ pancreatic cancer
- ❑ prostate cancer
- ❑ skin cancer
- ❑ thyroid cancer
- ❑ other: _____

Other/ Miscellaneous
- ❑ cataract
- ❑ glaucoma
- ❑ obesity
- ❑ other: _____
- ❑ other: _____

GYNECOLOGICAL HISTORY:

Number of Pregnancies (Gravidity): _____ Number of Births: _____

Birth Control Method: _____ Last Menstrual Period: _____

Age of Onset (Menarche): _____ Age at Menopause: _____

PREVENTATIVE HEALTH MAINTENANCE:

	DATE	CIRCLE RESULT		DATE
Colonoscopy	/ /	Normal / Abnormal	Influenza Vaccine	/ /
Mammogram	/ /	Normal / Abnormal	Pneumococcal Vaccine	/ /
Pap Smear	/ /	Normal / Abnormal	Tetanus Vaccine	/ /
Bone Density	/ /	Normal / Abnormal	Last Labs	/ /
Eye Exam	/ /	Normal / Abnormal	Other:	/ /
PSA:	/ /	Normal / Abnormal	Other:	/ /

CURRENT MEDICAL PROVIDERS:

SPECIALTY	PHYSICIAN NAME
Cardiologist	
Gastroenterologist	
Neurologist	
Ophthalmologist	
Podiatrist	
Psychiatrist	
Urologist	
Other:	
Other:	

SURGICAL HISTORY:

OPERATION	DATE

FAMILY HISTORY: Mark any of your family members that have had any of the following illnesses:

DISEASE NAME	FATHER	MOTHER	BROTHER	SISTER	PATERNAL GRAND-FATHER	PATERNAL GRAND-MOTHER	MATERNAL GRAND-FATHER	MATERNAL GRAND-MOTHER
coronary artery disease								
hyperlipidemia								
hypertension								
breast cancer								
cervical cancer								
colon cancer								
lung cancer								
prostate cancer								
skin cancer								
asthma								
COPD								
hepatitis C								
alzheimer's disease								
diabetes, type 1								
diabetes, type 2								
hypothyroidism								
osteoporosis								
alcoholism								
anxiety								
depression								
drug abuse								
obesity								
other:								
other:								

SOCIAL HISTORY

MY PERSONAL LIFESTYLE GOALS ARE: (Please check all that apply)

- ❒ Develop healthier eating habits
- ❒ Get regular physical activity
- ❒ Achieve/ Maintain a healthy weight
- ❒ Spend more quality time with family/ friends
- ❒ Maintain a cheerful, hopeful outlook on life
- ❒ Get adequate rest daily
- ❒ Freedom from dependence on tobacco/ alcohol
- ❒ Other:

I believe I am not meeting my above lifestyle goals because: _____

_____

Occupation: _____

Marital Status: _____

Number of children in household? _____

Do you have religious beliefs which prevents the use of blood products if you are very ill? ❒ Yes ❒ No

TOBACCO USE

Cigarettes

❒ Never Smoked

❒ Past Smoker

Quit Date_____ # of pack/year?_____

❒ Current Smoker

# of packs/day _____

Other Tobacco:

❒ Cigar ❒ Chew ❒ Pipe ❒ Snuff ❒ Vape

Are you interested in quitting? ❒ Yes ❒ No

Second Hand Smoke:

Smoke exposure in the home? ❒ Yes ❒ No

ALCOHOL USE

Do you drink alcohol?

❒ Yes ❒ No

drinks/week _____

Is alcohol use a concern for you or others?

❒ Yes ❒ No

DRUG USE

Do you use any recreational drugs? ❒ Yes ❒ No

If yes, indicate what type _____

_____

Have you ever used needles? ❒ Yes ❒ No

IMPLANTATION DEVICE:

Name of Device: _____ Serial Number: _____

QUESTIONS TO ASK YOUR HEALTHCARE TEAM:

_____

_____

PATIENT/GUARDIAN SIGNATURE: _____ Date: _____

Your Guide to Understanding **Central Coast Health Connect**

A Health Information Exchange for Monterey County

What is Central Coast Health Connect (CCHC)?

CCHC is a community health information exchange (HIE), a system established to help patients and healthcare providers securely share health information electronically. An HIE helps to ensure that only you and the caregivers you authorize — including doctors, hospitals, and labs — have secure, instant access to vital medical information necessary to provide you the best care possible.

Why is it important to participate in CCHC?

Many people see multiple care providers, often in separate locations. The information about their care, such as doctors' office visits, prescriptions, lab tests, and imaging, historically has also been kept separate. That fragmentation can lead to unnecessary duplication of services and increased safety risks. To increase safety, efficiency, and collaboration, leading-edge organizations are implementing health information exchanges to link patients and their care providers. When you and your healthcare providers participate in CCHC, your healthcare team can securely access and share pertinent medical information, enhancing the ability to make the best decisions for your care.

How is my information secure?

Protecting privacy is a top priority in the CCHC system. Access to patient data is strictly regulated. State and federal privacy laws require policies that are strictly followed and enforced. CCHC understands that patient privacy is essential, and we make every effort to ensure patient data is securely managed.

Can I get my test results electronically with CCHC?

Yes. A major benefit to patients is the CCHC patient portal. If you provide your email address when you register — depending on the services you receive — you will get an email invitation to join the CCHC patient portal. If you receive an invitation, please click the 'register' link within the email and follow the instructions to create your account. (Currently, CCHC does not allow dependent or minor patient portal accounts). Within four days following your visit, you will receive any (non-sensitive) test results or related health data.

What if I don't want to participate in CCHC?

If you don't want to participate in CCHC, you may choose to opt out. It is also important to understand that **opting out prevents the sharing of your information through CCHC between providers.** If they choose, your doctor and other care providers will still be able to individually use the electronic health information exchange to have your lab results, radiology reports, and other data sent directly to them. Previously, they may have received this information by fax, mail, or other electronic communication. If you still choose to opt out, please email:

cchc-help@centralcoasthealthconnect.org
or call (831) 644-7494

To learn more about Central Coast Health Connect, please call **(831) 644-7494** or visit:
centralcoasthealthconnect.org

State and federal laws regarding the electronic distribution of *sensitive* test results prevents us from providing you with all of your test results through the CCHC patient portal. For additional information about those results considered sensitive, please refer to California State Health and Safety Code 123148, particularly the following section:

". . . none of the following clinical laboratory test results and any other related results shall be disclosed to a patient by internet posting or other electronic means:

(1) HIV antibody test

(2) Presence of antigens indicating a hepatitis infection

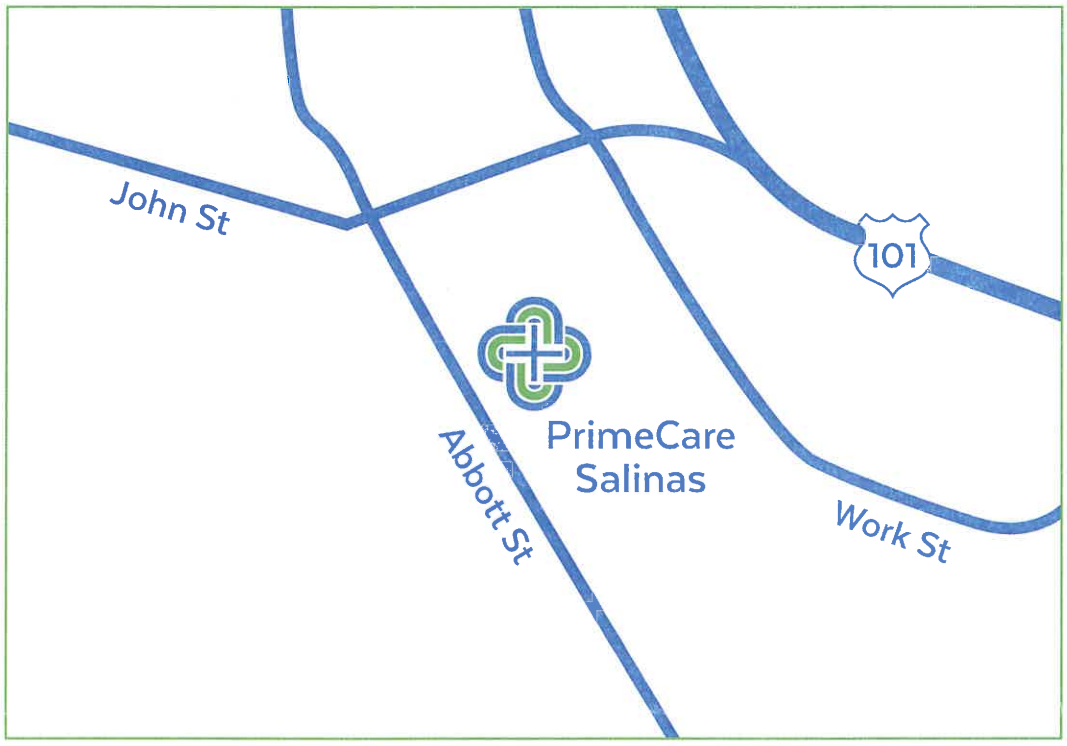
(3) Abusing the use of drugs

(4) Test results related to routinely processed tissues, including skin biopsies, Pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, if they reveal a malignancy."

CCHC
CENTRAL COAST HEALTH CONNECT

POS Reorder # 1901879
REV 12/20

PrimeCare - Salinas



PrimeCare - Monterey