Premier Healthcare
OF CALIFORNIA

Premier Healthcare of California, Inc.
405 South St. Suite F, Redding, CA 96001
Ph: 530-941-1017 / FAX: 530-241-1095
email: admin@premierhealthcarenow.com

NEW PATIENT APPLICATION

ALL ITEMS WITH ** MUST BE FILLED IN

Patient

*** First Name:** *** Last Name:** **MI:** *** Date of Birth:**

***Address:** *** City:** ***State:** *** Zip:**

***Home Phone:** **Cell Phone:** **Work Phone:**

***Email Address:**

***Gender:** M F *** SS#** **Driver's License # & State:** *** Preferred Language:**

***Marital Status:**

- Married
- Single
- Divorced
- Separated
- Widowed
- Life Partner

*** Preferred Contact**

- Mail
- Home Phone
- Cell Phone
- Text Message
- None

If text message, home phone or email Please confirm appropriate Numbers.

_____
_____
_____

*** Ethnicity:**

- Caucasian
- Hispanic /Latino
- Non-Hispanic
- Filipino
- Cambodian
- Other

_____

*** Race:**

- American Indian or Alaskan Native
- Asian
- African American
- Native Hawaiian/Other Pacific Islander
- White
- Other

_____

Referring Provider: **Primary Care Provider:**

Responsible Party (Guarantor/ POA)

First Name: **Last Name:** **MI:** **Date of Birth:**

Address: **City:** **State:** **Zip:**

Home Phone: **Cell Phone:** **Work Phone:**

SS# **Driver's License # & State:** **Relationship to Patient:**

Emergency Contact (For Minor or POA of Patient)

***First Name:** *** Last Name:** **MI:** **Date of Birth:**

Address: **City:** **State:** **Zip:**

***Home Phone:** *** Cell Phone:** *** Relationship to Patient:**

Insurance Please Give a Copy of your Insurance Card

(NONE) I AM PRIVATE PAY

Medicare Only

*Medicare Policy Number (Medicare Claim Number)	*Effective Date

Private Insurance Only

*Name Of Insurance Company	*Individual Policy Number	*Group Number	*Effective Date

Secondary Insurance

*Name Of Insurance Company	*Individual Policy Number	*Group Number	*Effective Date

Medical/ Medicaid Insurance

*Name Of Insurance Company	*Individual Policy Number	*Group Number	*Effective Date

I/We do herby consent to and authorize the performances of all treatments, surgeries/procedures and medical services deemed advisable by the physicians/Medical Providers and staff of Premier Healthcare of California, Inc. to me or the above named of whom I am the parent or legal guardian/Power of Attorney over. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.
I certify that the information provided by me in applying for payment under TITAL XVll of the Social Security act is correct and request on my behalf all authorized benefits.

I hereby authorized and instruct my insurance carrier(s) to make payment directly to the Premier Healthcare of California, Inc. (Payments) otherwise billable to me. I agree to personally pay for any charges that are not covered by or collected from any insurance program, including any deductibles and co-insurance amounts.

I am aware that I am responsible for any deductible, co-pay or any amount that is not covered by my insurance(s) and that I am ultimately responsible for my bill that I have requested medical services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I understand that a $25.00 fee will be billed when the bank returns checks.
I hereby authorized Premier Healthcare of California, Inc. to release any information necessary to insurance carriers regarding my illness and treatment. A photocopy of this assignment shall be considered as valid as the original.

I understand that I am directly responsible for all charges incurred for medical services for myself and/or my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Premier Healthcare of California, Inc. to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

I understand that Premier Healthcare of California, Inc. has the right to terminate provider/patient relationship with a written thirty-day notice to patient to allow patient to seek out new medical provider. Reasons for dismissal can be done for various reasons, i.e. Treatment non-adherence, Follow-up non-adherence, Office policy non-adherence. Verbal abuse, non-payment, Over use of prescription medication from other providers (Dr. shopping)

I understand my privacy. Premier Healthcare of California, Inc. regulates under HIPPA compliance. We are dedicated to maintaining the privacy of the patient individually identifiable health information (PHI). I acknowledge that in regards to medical services and treatments, records are maintained. We are required by law to maintain confidentiality of health information that identifies you. By signing, I understand that Premier Healthcare of California, Inc. follows federal and state law of your PHI by HIPPA standards.

I hereby authorize Premier Healthcare of California, Inc. to contact any healthcare facility or entity that I have been associated with to obtain my medical records on behalf, including: Pertinent medical records, medications, lab reports, radiology reports, emergency/urgent care records discharge summary, demographic information or any known medical reports that may be needed for my care.

_____ _____

***Patient Name (Please Print)** *** DOB:**

_____

***Name of Patients Responsible Party: (Please Print)**

_____ _____

***Patient/ POA/ Guardian Signature:** ***Date:**

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Insurance and Patient Financially Responsibility Consent

At Premier Healthcare of California, we would like all our patients and patients POA to understand that we do not do concierge medicine; meaning we do not provide patient with weekly, monthly or yearly fees for the services provided. We do however have cash paid care for those who do not have medical insurance.
Premier Healthcare is a sole practice that provides family practice in office and as well as in house visits to assisted living facilities as a courtesy to the betterment of our homebound patients. In no way are we in financial connection with said facilities other than working together for the best patient/resident care.
We bill insurance companies as a courtesy to our patients. Our policy is to provide the most convenient and best care to our patients at a reasonable cost. This is why we do not exceed the allowable by insurance unless discussed and acknowledged by the patient and or families involved prior to visits or procedures.

As a courtesy we bill your insurance for the cost of a visit or any needed procedures performed which would include visit time, medications, instrumentation and any needed product or devices needed for your treatment.
Though we do our best to be In-Network for the majority of insurance companies, it is impossible to know every small subcategory of health plans that are out there. There for it might be a possibility that Out-Of-Network billing would apply to your visit and care provided. For this reason here at Premier Healthcare of California, we do our best to insure that we are In-Network for all your care, we do however recommend that if you are concerned about your full understanding of your healthcare insurance plan that you contact your insurance companies for a full explanation of benefits, and to ensure that we are In-Network with your insurance company so your care will be covered to its fullest allowable. You may also reach out to Premier Healthcare or there associated billing company for further investigation of your benefits and what would be your total available cost, deductible and co-pay for your visits prior to requesting care from Premier Healthcare.

Please understand that billing does not take place within the office and it may take up to 3 months to 1 year for insurance to pay out and statements to be submitted to the patient. Please also understand that your insurance company may require a co-pay for each visit and yearly deductibles to be met before full insurance coverage is paid out on your behalf. Prior to your insurance policy coverage being met, financial responsibility is and will remain solely of the patient and/or patients POA to pay from their own personal account upon receipt of statement on visits and/or procedures provided by Premier Healthcare of California.

If you have a grievance on the amount, or questions on your final statements, please feel free to direct your questions to your insurance company as well please feel free to contact Premier Healthcare or the billing company about your concerns so that we may better help resolve your questions and situation.

Date: _____

Patients Name (Print): _____DOB:_____

POA/Guardian Name (Print): _____

Patients /POA Signature: _____

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Premier Healthcare has implemented a cancellation fee of $25.00 for patients seen in-office, who do not call to reschedule and cancel their appointment 24hrs in advance. This will be billed to you directly.

We do our best to keep patient care convenient and timely. We would appreciate the same in return as it will allow us to schedule patients that are in need to be seen sooner.

Thank you for your consideration

Premier Healthcare Team

I understand the reason for the cancellation fee and except the terms. I understand this does NOT apply to patient care within Assisted Living/Memory Care Facilities and only applies to IN-OFFICE Visits.

Patient Name: _____DOB:_____

Patient/POA Signature: _____ Date: _____

Patient Name: _____

Pharmacy Information

Name:

Address:

Phone:

Fax:

Medication: * List all medication you take, prescription and non-prescription, and dosage * (you may attach another paper)

○ **I do not take medications**

Medication Name	Dose	How often

Medication and Food Allergies: *List all known allergies (drugs, food, animals, etc.)

○ **NO Known Allergies**

Advanced Directives

- ○ NONE
- ○ DO NOT RESUSCITATE
- ○ DURABLE POWER of ATTORNEY Date Reviewed: _____
- ○ LIVING WILL
- ○ HC PROXY

Social History for Adult Patient:

Occupation: Employer:

Do you have Children? ○ ○	How Many?	Female(s)	Male(s)
Tobacco Use ○ NO	○ Daily ○ Weekly ○ Former /Year Quit:	○ Chewing ○ Cigar ○ Smokeless ○ Pipe ○ Cigarette	
Alcohol Use ○ NO	○ Daily ○ Weekly ○ Former/Year Quit:	○ Beer ○ Liquor ○ Wine ○ Other	
Exercise Activity ○ NO	○ Daily ○ Weekly ○ Former/Year Quit:	Sleep Pattern: ○ Changes ○ No Changes	
Caffeine Use ○ NO	○ Daily ○ Weekly ○ Former/Year Quit:	○ Chocolate ○ Soda ○ Coffee ○ Tea	

Patient Name: _____

Medical History – Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
○ NONE		○ Gallbladder Disease	
○ Allergies		○ GERD (Reflux)	
○ Anemia		○ Hepatitis C	
○ Angina		○ Hyperlipidemia	
○ Anxiety		○ Hypertension	
○ Arthritis		○ Irritable Bowel Disease	
○ Asthma		○ Liver Disease	
○ Atrial Fibrillation		○ Migraine Headaches	
○ Benign Prostatic Hypertrophy		○ Myocardial Infarction	
○ Blood Clots		○ Osteoarthritis	
○ Cancer – TYPE		○ Osteoporosis	
○ Cerebrovascular Accident		○ Peptic Ulcer Disease	
○ Coronary Artery Disease		○ Renal Disease	
○ COPD (Emphysema)		○ Seizure Disorder	
○ Crohn's Disease		○ Thyroid Disease	
○ Depression		○ Weight loss/gain	
○ Diabetes – TYPE		○ Other	

Surgical History – Check if you have received the following procedures and year performed

Surgical Procedure	Year	Surgical Procedure	Year
○ None			
○ Angioplasty		**Male Only**	
○ Angioplasty w/Stent		○ Prostate Biopsy	
○ Appendectomy		○ TURP ○ (Trans-urethral resection of prostate)	
○ Arthroscopy Knee		○ Vasectomy	
○ Back Surgery		○ Other	
○ CABG (Heart Bypass)		○ Other	
○ Carpal Tunnel Release			
○ Cataract Extraction		**Female Only**	
○ Cholecystectomy (Gallbladder)		○ Augmentation Mammoplasty	
○ Colectomy		○ Bilateral Tubal Ligation	
○ Colostomy		○ Breast Biopsy	
○ Gastric Bypass		○ Cesarean Section	
○ Hernia Repair		○ D & C	
○ Hip Replacement		○ Hysterectomy	
○ Knee Replacement		○ Mastectomy	
○ LASIK		○ Myomectomy	
○ Liver Biopsy		○ Reduction Mammoplasty	
○ Pacemaker		○ TAH/ BSO	
○ Small Bowel Resection		○ Vaginal Hysterectomy	
○ Thyroidectomy		○ Other	
○ Tonsillectomy		○ Other	

Health Maintenance – Check if you have received the following and date of most recent exam

Exam	Date	Exam	Date
○ None		○ GYN Exam	
○ Breast Exam		○ Influenza Vaccine	
○ Cardiac Stress Test		○ Lipid Panel	
○ Colonoscopy		○ Mammogram	
○ DEXA Scan		○ PAP Test	
○ Echocardiogram		○ Physical Exam	
○ EKG		○ Pneumococcal Vaccine	
○ Eye Exam		○ Pulmonary Function Test	
○ FOBT (Stool card for hidden blood)		○ Sigmoidoscopy	
○ Foot Exam		○ Tetanus Vaccine	

Patient Name: _____

Family History – check if any family member(s) has had any of the following conditions

○ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other	Other	Other
○ Alcoholism	○	○	○	○	○	○	○
○ Allergies	○	○	○	○	○	○	○
○ Alzheimer's Disease	○	○	○	○	○	○	○
○ Asthma	○	○	○	○	○	○	○
○ Blood Disease	○	○	○	○	○	○	○
○ CAD (Heart Attack)	○	○	○	○	○	○	○
○ Cancer – TYPE	○	○	○	○	○	○	○
○ CVA (Stroke)	○	○	○	○	○	○	○
○ Dementia	○	○	○	○	○	○	○
○ Depression	○	○	○	○	○	○	○
○ Developmental Delay	○	○	○	○	○	○	○
○ Diabetes	○	○	○	○	○	○	○
○ Eczema	○	○	○	○	○	○	○
○ Hearing Deficiency	○	○	○	○	○	○	○
○ Hyperlipidemia (High Cholesterol)	○	○	○	○	○	○	○
○ Hypertension	○	○	○	○	○	○	○
○ Irritable Bowel Disease	○	○	○	○	○	○	○
○ Learning Disability	○	○	○	○	○	○	○
○ Mental Illness	○	○	○	○	○	○	○
○ Tuberculosis	○	○	○	○	○	○	○
○ Obesity	○	○	○	○	○	○	○
○ Osteoarthritis	○	○	○	○	○	○	○
○ Osteoporosis	○	○	○	○	○	○	○
○ PVD (Peripheral vascular disease)	○	○	○	○	○	○	○
○ Renal Disease	○	○	○	○	○	○	○
○ Other	○	○	○	○	○	○	○
○ Other	○	○	○	○	○	○	○

For Pediatric Patient:

Patient Resides with:	Primary	○ Mother	○ Father	○ Both Parents	○ Other
	Secondary	○ Mother	○ Father	○ Other	

Mother's Occupation:

Father's Occupation:

Parent's Relationship:

- ○ Married
- ○ Divorced
- ○ Single
- ○ Separated
- ○ Widowed

Childcare:

- ○ Mother
- ○ Father
- ○ Sibling
- ○ Grandparent
- ○ Nanny
- ○ Daycare

Tobacco Exposure: Yes No
Smokers at Home: Yes No

Patient is current Smoker? Yes No

Please have available

COPIES of ALL

- **INSURANCE CARDS:**
- **Driver's License:**
- **Medication List:**

If Applicable Please Provide:

- **Power of Attorney for**
- **Medical and/or Financial and/or**
- **Advanced Directive:**

Depression Assessment Questionnaire

Name: _____ DOB: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle or Check to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns				

Total Points	

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very Difficult _____ Extremely difficult_____