Lincoln Internal Medicine

Patient Information

❑ Male ❑ Female Doctor: _____

Patient's Name: _____ Home Phone: _____

Address: _____

City: _____ State/Zip: _____

Patient's Email Address: _____

Marital Status: ❑ S ❑ M ❑ W ❑ Div ❑ Sep Date of Birth: _____ Age: _____

SSN: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Spouse's Name: _____ Date of Birth: _____ SSN: _____

Spouse's Employer: _____

Employer's Address: _____ Work Phone: _____

Spouse's Home Address:
(if divorced or separated): _____ Home Phone: _____

City: _____ State/Zip: _____

Person to notify in case of emergency (note: person should not live at same residence):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Insurance Information (indicate which insurance is primary [1] and which is secondary [2] in boxes below)

Name of Insurance: _____

Insurance ID # _____ Group #: _____

Subscriber: ❑ Self ❑ Spouse ❑ Other: _____

❑ Primary ❑ Secondary

Name of Insurance: _____

Insurance ID # _____ Group #: _____

Subscriber: ❑ Self ❑ Spouse ❑ Other: _____

❑ Primary ❑ Secondary

OVER, PLEASE

Please complete this section if patient is a minor.

Student: ❑ Full Time ❑ Part Time

Responsible Party's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____ Home Phone: _____

City: _____ State/Zip: _____

Employer: _____ Work Phone: _____

Employer's Address: _____

Authorization for assignment of benefits and information release

I, the undersigned, authorize payment of medical benefits to Lincoln Internal Medicine for any services furnished to me by the physicians. I understand I am financially responsible for any services not covered by my insurance. I further agree to pay reasonable attorney fees and court costs in the event that legal action becomes necessary to enforce this contract. I also authorize you to release my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date: _____ Signed: _____

** Upon receipt of the necessary information, we will bill any preferred plans in which we participate. We will also bill private insurance companies for certain procedures as a courtesy to assist you with your reimbursement. Payment is expected within thirty days. If payment is not received within this time period, any charges will become your immediate responsibility.

How did you hear about our practice? _____

_____

_____

_____

_____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

Pharmacy Name_____ Phone_____

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

Lincoln Internal Medicine
801 Sterling Parkway, Suite 120
Lincoln CA 95648
Tel: (916) 408-3773
Fax: (916) 408-3853
www.lincolnimed.com

PRIVACY POLICY

Our practice policy is that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) of our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and protected health information to provide the highest quality medical care possible while protecting the protected health information and confidentiality of our patients.

Our practice and its physicians and staff will not use or disclose PHI for uses outside of treatment, payment or healthcare operations (TPO) without an authorization from the patient.

Our practice will use and disclose PHI to remind patients of their appointments within the minimum necessary standard.

We recognize that patients have a right to privacy. Our practice and its physicians and staff respect the dignity of the patient at all times and treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete.

We may permit access to medical records with a written request. The request must be approved by our practice. If we deny the request, then we must inform the patient that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the appeal.

We will provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

Our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

Our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff will adhere to this policy. Violations of this policy will not be tolerated by our practice and is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions.

We may change this privacy policy at any time. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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PATIENT RIGHTS

Lincoln Internal Medicine has adopted the following written policies concerning the rights and responsibilities of all patients.

PATIENTS HAVE THE RIGHT:

1. To considerate and respectful care; cultural, psychosocial, spiritual, personal values and beliefs will be respected. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.
2. To every consideration of his/her privacy concerning his/her medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present. Disclosure of records is treated confidentially and except when required by law, patients are given the opportunity to approve or refuse their release.
3. To receive, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis.
4. To participate in discussions involving their health care.
5. To be informed of patient rights, Lincoln Internal Medicine's expectation of patient conduct and responsibilities, services available, provisions for after hours care, fees and payment policies.
6. To express suggestions to Lincoln Internal Medicine, to voice complaints, and have those complaints impartially investigated with a response in no more than seven business days. Complaints should be directed to the Office Manager.

PATIENT RESPONSIBILITIES

1. Bring your insurance card to each visit –notify receptionist if there are changes to home address, phone number or insurance.
2. All co-payments, deductibles and other patient portion due for non-covered benefits will be collected at the time of service.
3. We require at least 48 hours notice for an appointment cancellation.
    a. A patient will be discharged from the practice if proper notice is not given for cancellation of an appointment.
4. All visits (Coumadin Clinic, BP check, injections) to Lincoln Internal Medicine require an appointment.
5. Be respectful of other patients' privacy while checking in.
6. To refill a prescription that was prescribed to you by Lincoln Internal Medicine, please call your pharmacy. They will in turn call/fax our office to complete the refill process.
    a. Please allow 2-3 business days for prescription refills
    b. If you need a refill on a prescription that was issued by another physician, an appointment may be necessary.
7. All referrals, once issued to you by our doctor take 2-3 business days to process.
    a. Authorizations for services may take an additional 3 business days to process.
8. Please allow 5 business days for results to be received and interpreted by your physician.
9. You may obtain a copy of your medical record upon written request.
    a. The charge for reproducing your medical record is .25 per page, clerical fees and postage.
10. There is a fee of $20 to the patient for completion of disability, DMV, EDD, etc. forms. This must be paid prior to the form being filled out.

_____ _____

Patient Signature Date

Lincoln Internal Medicine
801 Sterling Parkway, Suite 120
Lincoln CA 95648
Tel: (916) 408-3773
Fax: (916) 408-3853
www.lincolnimed.com

Acknowledgement of Receipt of Practice Privacy Policy and Authorization for Use or Disclosure of Protected Health Information

_____ **Please initial here to acknowledge that you have received a copy of Lincoln Internal Medicine's Privacy Policy.**

I authorize my physician and/or administrative and clinical staff to disclose information regarding my care and treatment at Lincoln Internal Medicine to:

_____

This authorization shall be in force and effect until I inform Lincoln Internal Medicine that I wish to revoke the authorization. I understand that I may revoke this authorization by writing to the Privacy Officer at 801 Sterling Parkway, Suite 120, Lincoln CA 95648. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except when health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

LINCOLN INTERNAL MEDICINE
801 STERLING PARKWAY, SUITE 120
LINCOLN CA 95648
(916) 408-3773 FAX (916) 408-3853

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ DOB:_____

I authorize: _____
(name of person and or facility which has information)

_____
(Street address, City, State and Zip Code)

to release health information to: LINCOLN INTERNAL MEDICINE
801 STERLING PARKWAY, SUITE 120
LINCOLN CALIFONIA 95648

Please specify the type of health information that you authorize to be released:

☐ MEDICAL ☐ MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information:_____

Date(s) of treatment:_____

The following information will not be released unless you specifically authorize it:

☐ I specifically authorize release of information pertaining to drug and alcohol abuse diagnosis or treatment (C.F.R. §2.34 and §2.35)

☐ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code § 120980 (g).

☐ I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j).

The purpose of this release is:

☐ At the request of the patient/patient representative

☐ Other (state reason):_____

Notice:

LIM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentially laws.

Your Rights:

This authorization to release health information is voluntary. Treatment, payment, enrollment of eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine the entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by your or your representative and delivered to April Hillard, Health Information Manager at Lincoln Internal Medicine. The revocation will take effect when LIM receives it, except to the extent that LIM or others have already relied on it.

You are entitled to receive a copy of this authorization

Expiration of Authorization:

Unless otherwise revoked, this authorization expires on _____(insert applicable date or event).
If no date is indicated, the authorization will expire in 12 months from the date of my signing.

_____ _____
Print Name Signature (Patient,Parent,Guardian)

_____ _____
Date Time Relationship to Patient (i.e. Parent Guardian, Conservator, Patient Representative)

_____
Witness (only if patient is unable to sign)
Interpreter