STEP 1

Complete & Submit Pages A to G

Patient Signature

Email: requests@palmoremd.com

Patient Registration

Last Name _____ First _____ Middle _____

Home Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell # _____ Work # _____

Sex: ☐ Male ☐ Female Birthdate _____ Age _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birthdate _____

Social Security # _____ Employer _____ Phone # _____

Work Address _____ City _____ State _____ Zip _____

In case of emergency, please notify _____ Phone # _____

Insurance Information

☐ *CASH PAY/ NO INSURANCE?*

Primary Insurance _____ Secondary Insurance _____

Subscriber's Last Name _____ Subscriber's Last Name _____

Subscriber's First Name _____ Subscriber's First Name _____

Social Security # _____ Group # _____ Social Security # _____ Group # _____

Employer _____ Employer _____

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or major medical benefit to which I am entitled to and I hereby authorize you to make direct payment to **David A. Palmore, M.D., Inc.** of any benefits payable to me under the conditions of my policy. I understand I am financially responsible for charges not covered by this assignment.

Signature _____ Date _____

DAP

DAVID A. PALMORE M.D.

Internal Medicine for over 30 years.

Patient Questionnaire

1. Reason for appointment?

2. Date of onset?

3. Have you been treated by any other physician for this condition?

4. What treatment was given?

5. Are you currently on any medications?

6. Are you taking any narcotic pain medication?

7. Are you planning to ask for pain medications?

8. Are you taking any medications to treat sleep or anxiety?

9. Are you planning to ask for medications to treat sleep or anxiety?

10. Reason for leaving previous physician?

By providing your signature, you are aware that the physician does not feel comfortable prescribing controlled substances of any kind. Please submit this questionnaire and packet request as soon as possible that the physician may review then schedule an appointment for you. Thank you!

Patient Signature: _____

B

PATIENT MEDICATION RECORD

PATIENT NAME:	D.O.B:
ALLERGIES:	
PHARMACY:	

MEDICATIONS

DATE:	MEDICATION	DOSE	ROUTE	FREQ	DC'D	SAMPLE

C

Patient 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
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ 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 currently have or have had in the past year.

- ☐ 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

Pharmacy:

_____

_____

_____

_____

Pharmacy Name_____ Phone_____

Allergies:

_____

_____

_____

_____

_____

Health History

Family History (Fill in health information about your immediate family)

	Age	State of Health	Age at Death	Cause of Death
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				

Check (✓) if your blood relatives had any of the following:

☑	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer (type)	
	Chemical dependency	
	Diabetes	
	Heart disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other:	

Hospitalizations & Surgeries

Year	Hospital	Reason for Hospitalization and Outcome

Date	Serious Illness or Injury	Outcome

Have you ever had a blood transfusion? **Yes** or **No** if yes, please give approximate date(s): _____, _____, _____

Health Habits

(Circle which substances you use and describe how much you use)

Alcohol: _____

Caffeine: _____

Drugs: _____

Tobacco: _____

Other: _____

Occupational

(Circle if your work exposes you to any of the following)

Heavy Lifting

Hazardous Substances

Stress

Other: _____

_____

Pregnancies

Year of Birth | Sex | Complications, if any

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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 staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

David A. Palmore, M.D., Inc.

Financial Policy

Welcome to David A. Palmore, M.D., Inc. Our goal is to provide you with the highest quality care possible. To maintain this objective, we have partnered with **Stanford Medical Billing (S.M.B) in Fresno, CA** to better serve our patients with S.M.B's qualified staff to answer questions that you may have regarding your insurance &/or billing issues. Please do not hesitate to reach out to S.M.B. directly via **Phone 559-438-1245** or **Email:** frontdesk@stanfordmedicalbilling.com. *Allow 24 to 48 hours for a representative to respond to your request.*

Our office contracts with the most Preferred Provider Organizations (PPOs). You must verify that David A. Palmore, M.D., Inc. is contracted with your plan and benefits apply. If your health care does not cover the expenses from any one of the plans, we require that you pay all deductible, co-pay, and co-insurance amounts at the time of service. We will bill your plan for the remaining balance. If we do not contract with your plan, we require payment in full at the time of service. Please remember medical services are rendered directly to each patient at their request, therefore **each patient is responsible to us for payment.**

By signing below, you acknowledge that David A. Palmore, M.D., Inc. is NOT a Medi-Cal Provider, and you hereby confirm that you (or the patient, if you are signing as a responsible party) are not a Medi-Cal patient. You further acknowledge that failure to provide accurate insurance information or information about your Medi-Cal status could be considered fraudulent and could carry civil and criminal penalties. Additionally, this could result in our office terminating the professional relationship with the patient and/or billing you as a private pay patient.

A copy of your insurance card is required at each visit. It is your responsibility to notify David A. Palmore, M.D., Inc. of any changes in your coverage status and effective dates. This information will be kept in your medical file.

Charges billed to your insurance plan will be noted on your account until payment and/or an Explanation of Benefits (EOB) is received from the insurance company. We will bill your plan directly as a service to you, but not substitute your primary responsibility for payment. Charges that have not been paid by the insurance, are the patient's responsibility. All patient-due balances are expected to be paid upon receipt of an EOB. We may require a guarantee of payment in the form of a credit card which will be used to satisfy future patient responsibility balances. Alternatively, patients may place a deposit on the account toward future balances.

We may provide account balance and payment notification via SMS message (text), email, and/or phone in addition to the normal customary process, and you hereby grant authorization for us to do so. Requests for alternate methods of payment (including payment plans) will be reviewed on an individual basis. Every effort will be made to come to an agreed-upon method of payment and resolution. *Failure to cooperate in a timely agreed manner can lead to being sent to collections and/or a permanent dismissal from the medical practice.*

$25.00: Service charge on *all returned checks*.
$35 or $70.00: No Show/Cancellation/Missed Appointment or Physical Exams
$25.00: Form Fee (ex. DMV, FMLA)
$50.00: Personal transfer of records or release of medical information

I have read the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all medical services rendered. I understand that I am covered by a third-party payment service such as an insurance plan, your office may bill them directly as a convenience to me, but I am personally responsible for such charges until they are paid in full.

Assignment and Release: *I hereby authorize my insurance benefits to be paid directly to David A. Palmore, M.D., Inc. to release any information required to process my claim:*

Patient Name (Print):_____ Date of Birth:_____

Responsible Party Signature:_____ Date:_____

F

HIPPA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 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. For this reason, our practice has 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. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office 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 of 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 nominal value.

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

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.

I, _____ do hereby agree to the terms set forth above and any subsequent
(Patient or Guardian)

DATE_____

changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

G

DAP
DAVID A. PALMORE M.D.
Internal Medicine for over 30 years.

1187 East Herndon Avenue - Suite 104
Fresno, CA 93720
T: 559.449.4547
FAX: 559.761.1530
E: records@palmoremd.com

REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____

INFORMATION TO BE RELEASED FROM:

Name: _____
Address: _____
_____
Fax: ( ) _____ - _____

INFORMATION TO BE RELEASED TO:

Name: _____
Address: _____
_____
Fax: ( ) _____ - _____

INFORMATION FOR THE PURPOSE OF:

___ Continued care to other MD (no charge)
___ Personal Use ($25.00 pre-paid) / Other

SEND THE FOLLOWING:

___ Consultations
___ Correspondence
___ EKG, Treadmill
___ History/Physical
___ HIV Test Results
___ Lab Reports (last)
___ Mammogram (last)
___ Medication List
___ Progress Notes
___ Rx Refill List
___ X-Rays:
___ Other:

~YOUR PROMPT ATTENTION TO THIS REQUEST IS GREATLY APPRECIATED~

_____ _____
Signature of Patient or Legal Guardian Date

H

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RELEASE OF INFORMATION

NAME OF PATIENT: _____

DATE OF BIRTH: _____

1. _____
2. _____
3. _____
4. _____

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

J