# Rancho OB/GYN

PERSONALIZED MEDICAL CARE FOR WOMEN

*Better Health Starts Here*

## NEW PATIENT FORM

Patient's Name: _____ DOB: _____

Email Address:_____

Cell Phone: _____ Home Phone: _____

**NOTICE OF PRIVACY PRACTICES**

This notice describes how health information about you, as our patient, may be used and disclosed during the course of your treatment. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Rancho OB/GYN is required by law to maintain your confidentiality except under certain circumstances. The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. During a lawsuit or similar proceeding in response to a court order.
3. To a law enforcement official with a subpoena or court order
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, we will only made disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities
6. To federal officials for intelligence and national security activities authorized by law
7. To correctional institutions or law enforcement while you are detained, arrested or incarcerated.
8. For Workers Compensation Lawsuits where you have filed a lawsuit.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we do not

disclose your health information to certain individuals involved in your care, such as family members and friends. However, we may be required by law to disclose the information to a third party in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of your health information, including patient medical records and billing records. You must submit your request in writing to your physician.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to your physician. You must provide us with a reason that supports your request for amendment.
5. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: Privacy Officer, 25395 Hancock Ave. Ste 210, Murrieta, CA 92562. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
6. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
7. **If you choose to have a third party present during an office visit, the discussion of any medical information will result in a waiver of your doctor-patient prvilege.**

**CONSENT TO CONTACT PATIENT**

Unless you notify our office otherwise, Rancho OB/GYN will be contacting you from time to time at the phone number, email address, and/or home address listed in your chart. This includes calling or emailing you with lab or imaging results, sending you appointment reminders, and returning phone calls.

☐ By checking this box, I do not agree to received appointment reminders by automated text messages and email messages.

☐ By checking this box, I do not agree to be contacted by Rancho OB/GYN via telephone calls and emails for my test results.

**NOTICE OF E-PRESCRIPTION REQUIREMENTS**

Effective January 1, 2022, all prescriptions issued by our office must be done electronically. This office complies with the e-prescription requirements of California.The benefits of issuing a prescription on line are that: It allows your doctor to see what drugs are covered by your insurance plan; Provides your doctor with a list of medcations you are already taking to avoid an adverse reaction; and allows your doctor to receive notification from the pharmacy when your prescription has been filled.

Patient Name:_____ DOB:_____

**CONSENT TO DISCLOSE MEDICAL INFORMATION TO THIRD PARTY**

☐ By checking this box, I permit Rancho OB/GYN to disclose my protected helath information with the persons listed below. I understnat that I may revoke my consent at any time. Revocation of any consents must be in writing.

Name_____ Relationship_____

**CONSENT TO TREATMENT**

1. I acknowledge that I have read and received the privacy practices from Rancho OB/GYN.
2. I consent to be treated by Rancho OB/GYN, and I understand that Rancho OB/GYN cannot guarantee me the outcome of the medical treatment.

I hereby consent to be treated by Rancho OB/GYN:

Date: _____ Signature: _____

**IF PATIENT IS A MINOR**

1. I am an authorized parent or guardian of the above-referenced minor. I have legal authority to authorize Rancho OB/GYN to treat my child.
2. I understand that California law requires the doctor to speak with my child alone and I may not be allowed to be present during the exam.
3. I also understand that California law may prohibit the medical provider from disclosing to me any discussions the provider has with my child.
4. I consent to allow my minor to be treated by Rancho OB/GYN, and I understand that Rancho OB/GYN cannot guarantee me the outcome of the medical treatment.

Parent or Guardian Name: _____

Date: _____ Signature: _____

25395 Hancock Ave. Suite 210
Murrieta, CA 92562
www.ranchoobgyn.com
Phone: (951) 600-7066
Fax: (951) 600-7783
Email: admin@ranchoobgyn.com

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## PATIENT PAYMENT AGREEMENT

PATIENT INFORMATION (Please complete ALL information) Today's Date: _____

Patient Name:_____ Date of Birth: _____

Street Address: _____City: _____ State: _____ Zip _____

Driver's License # _____ SS # _____

Home Phone: _____ Employer: _____

Work Phone: _____ Occupation: _____

Cell Phone: _____ E-Mail: _____

## PHARMACY INFORMATION

Pharmacy Name: _____

Street Address: _____ City: _____ State: _____

## INSURANCE INFORMATION:

Primary Insurance:_____ Secondary Insurance: _____

☐HMO ☐PPO ☐POS ☐HSA ☐HMO ☐PPO ☐POS ☐HSA

Insured's Name: _____ Insured's Name: insured

Relationship to Patient: _____ Relationship to Patient: _____

INS #: _____ INS #: _____

Primary Doctor: _____ Dr. Phone Number _____

25395 Hancock Ave. Suite 210
Murrieta, CA 92562
www.ranchoobgyn.com

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**EMERGENCY INFORMATION (nearest relative not living with you)**

Name: _____ Phone: _____

**PAYMENT AGREEMENT FOR SERVICE RENDERED**

1. I agree to be financially responsible for amounts owed to Rancho OB/GYN; this includes the cost of all deductibles, all non-covered services, all unauthorized procedures performed by Rancho OB/GYN.
2. If I am a cash patient, I agree to pay the entire cost of the visit at time services are rendered.
3. I agree to pay any monies owed directly to Rancho OB/GYN even if I have health insurance and expect to be reimbursed by my insurance company.
4. If I have health insurance, I agree to pay any copayment at time of service. If I have a deductible which has not been met, I will be charged an additional fee that will be applied towards the deductible. After my insurance has been billed, I will receive a letter notifying me whether I owe additional money or I am entitled to a refund. If I owe additional money, I agree to pay Rancho OB/GYN within 30 days of receipt of notice. If I am entitled to a refund Rancho OB/GYN will reimburse me the amount of the overpayment or apply the credit towards my next visit.
5. I understand that some insurance carriers do not cover routine exams and preventative care visits, I agree to pay Rancho OB/GYN for the cost of all non-covered services.
6. I hereby authorize my insurance company to pay Rancho OB/GYN directly for any services provided to me by their office. This authorization will remain in effect until revoked in writing by the undersigned.
7. I hereby authorize Rancho OB/GYN to release any information acquired in the course of my examination/ treatment to my insurance company in order to obtain payment on my behalf.

I agree to be bound by the financial policies of this agreement:

Date: _____ Patient Name: _____

_____
Signature of patient or Authorized Adult
(If patient is a minor)

_____
Name of Parent or Guardian if patient is a minor

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