



Valley View Wellness
 Medical Center
 caring for generations

Patient Registration Form
 (Please Print)

General information

Name

LAST _____ FIRST _____ MIDDLE _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

SEX M F DRIVERS LICENSE # _____ STATE _____

MARITAL STATUS: Married Single Divorced Widowed

PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

Addresses

Home Address

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

EMPLOYER _____

OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE _____ EMAIL ADDRESS _____

IN CASE OF EMERGENCY CONTACT _____ PHONE _____

Primary Insurance

NAME OF PRIMARY INS CO _____ PHONE _____

ID/POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER/INSURED _____ RELATIONSHIP _____ SEX _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMPLOYER NAME _____ EMPLOYER PHONE _____

Secondary Insurance

NAME OF SECONDARY INS CO _____ PHONE _____

ID/POLICY NUMBER _____ GROUP NUMBER _____

SUBSCRIBER/INSURED _____ RELATIONSHIP _____ SEX _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

EMPLOYER NAME _____ EMPLOYER PHONE _____

I, the undersigned, assign directly to Valley View Wellness Medical Center, all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the medical center to release all information necessary to secure payment of benefits.

Signature _____ Date _____

(If the patient is a minor, signature of parent or guardian authorizing treatment)

Patient Authorization to Use or Disclose Protected Health Information

I, _____, understand Valley View Wellness Medical Center is not authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of Valley View Wellness Associates, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Names of person(s) other than myself authorized by this form to use and disclose my protected health information (family members, etc) _____

Description of the information to be used or disclosed (check all that apply)

The patient's entire medical record (NOTE: This requires an explanation why the entire record may be disclosed).

The patient's demographic information (check all that apply)

Name

Address

State/Zip Code only

Telephone

Age

Gender

Race

Other: _____

Medical Data / Information as related to

Specific condition(s)

Specific professional service(s)

Specific medication(s)

Other _____

I authorize Valley View Wellness Associates to contact me by mail, fax or phone regarding information or services that may be helpful or beneficial to you:

Signature: _____ Date: _____



Health History Checklist

Patient Name _____ **Date** _____

History of Past Illness: Please mark on "yes" or "no" to indicate if you have had any of the following:

Childhood

Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other serious diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever or		_____	
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No	heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Abnormalities	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Adult

Have you ever had any serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what reason?	_____
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Operations

Have you ever had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please list _____	_____
		_____	_____
		_____	_____

Injuries

Have you ever had any broken bones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any head concussions or injuries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been knocked unconscious?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Family History

<i>Relative</i>	<i>Their General Health Condition</i>
Father living? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mother living? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Brother/Sister living? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Husband/Wife living? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Son/Daughter living? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Has any blood relative ever had

Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout or Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Social History

Please check as appropriate Single Married Separated Divorced Widowed

Are you living with your husband, wife, or significant other? Yes No

Do you have dependents at home? Yes No

Do you drink alcoholic beverages? Never Rarely Moderately Daily

Systemic Review

General	Skin	Frequent infections or boils	<input type="checkbox"/> Yes <input type="checkbox"/> No
Good health most of your life?	Skin disease		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	Abnormal pigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Recent weight change?	Hives, eczema or rash		
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Head, eyes, ears, nose & throat	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness or unconsciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye disease or injury	Itching eyes or nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Impaired hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses?	Sneezing or runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double vision	Nosebleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Headaches	Chronic sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Continued>>



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Neck		Respiratory		Respiratory	
Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma or wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enlarged glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constant or frequent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiovascular		Gastrointestinal		Gastrointestinal	
Chest pain or angina pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of hands, feet, ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does food stick in throat	<input type="checkbox"/> Yes <input type="checkbox"/> No
shortness of breath with walking or lying down	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful bowel movements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Awakening in the night	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black stools	<input type="checkbox"/> Yes <input type="checkbox"/> No
2 blocks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peptic ulcer (stomach)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids or piles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart trouble or heart attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting blood or food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent change in bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Gallbladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cramping or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Liver trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Genitourinary		Locomotor-Musculoskeletal		Neuro-Psychiatric	
Loss of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness of muscles or joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been advised to see a psychiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nighttime urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever have or had fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bright's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in calves or buttocks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning or painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No			Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Hematologic		Endocrine		Allergies & Sensitivities	
Slow to heal after cuts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin or other antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hormone therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Morphine, codeine, demerol, or other narcotics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in hat or glove size	<input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin, empirin, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in hair growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Iodine or merthiolate	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive bleeding after a tooth extraction or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin is colder than before or dryer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other drug or medication _____	
Bruising or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Drugs taken recently		Gynecological (Women only)			
Cortizone	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age periods started _____			
ACTH	<input type="checkbox"/> Yes <input type="checkbox"/> No	How long do periods last _____			
Anticoagulants	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of pregnancies _____			
Tranquilizers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number miscarriages _____			
Blood pressure medicines	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last cancer smear & results _____			
Treatment for asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any pain with your periods _____			
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Number of children _____ Ages _____			
Other _____					



**FINANCIAL POLICY AND AGREEMENT
SELF-PAY & HEALTH INSURANCE COVERAGE**

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance and even if we bill your insurance company directly, you may be responsible for copayment, coinsurance, deductible, and noncovered amounts. For your convenience, our office accepts personal checks, credit cards, and cash, and when appropriate, can provide you with mutually agreed upon payment plan. It's also important to note that all cosmetic treatments are not covered by any health insurance plan and are due at the time of service. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" changes – the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, copayment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we writeoff the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of NonSufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Valley View Wellness Medical Center financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Valley View Wellness Medical Center.

In the event Valley View Wellness Medical Center agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Valley View Wellness Medical Center to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly) _____

Patient Signature _____

Date _____

**STANDARD PATIENT/PHYSICIAN
ARBITRATION AGREEMENT**

1) It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Valley View Wellness Medical Center, and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.

3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree of three medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as their pro rata share of arbitration expenses.

4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.

5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and canceled by written notice delivered to Valley View Wellness Medical Center within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.

6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here: _____

7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfaction any questions he/she may have had regarding the arbitration agreement with Valley View Wellness Medical Center, Inc. an associate physician, or authorized legal representative of Valley View Wellness Medical Center, and he/she has freely negotiated all terms herein set forth.

8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: YOUR SIGNATURE INDICATES YOU AGREE TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Dated: _____

Patient, Parent, Guardian, or Authorized Representative _____

If signed by someone other than the patient, indicate relationship: _____

Physician's agreement to arbitrate: Inconsideration of the foregoing execution of the Patient Physician Arbitration Agreement, Valley View Wellness Medical Center and Staff likewise agree to be bound by the terms set forth in agreement.



Valley View Wellness
 Medical Center
 caring for generations

Patient Registration Form
(Please Print)
Workers Comp/Personal Injury

General information

Name
 LAST _____ FIRST _____ MIDDLE _____
 DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
 SEX M F DRIVERS LICENSE # _____ STATE _____
 MARITAL STATUS: Married Single Divorced
 PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

Addresses

Home Address
 STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE _____ CELL PHONE _____
 EMAIL ADDRESS _____

Employer
 OCCUPATION _____
 WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
 WORK PHONE _____ EMAIL ADDRESS _____
 IN CASE OF EMERGENCY CONTACT _____ PHONE _____

PHARMACY _____ PHONE _____ CITY _____

Primary Insurance

NAME OF PRIMARY INS CO _____ PHONE _____
 ID/POLICY NUMBER _____ GROUP NUMBER _____ CLAIM NUMBER _____
 SUBSCRIBER/INSURED _____ RELATIONSHIP _____ SEX M F
 DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
 EMPLOYER NAME _____ EMPLOYER PHONE _____
 ADJUSTOR NAME _____ ADJUSTOR PHONE _____

Attorney Information

WORKERS COMP	PERSONAL INJURY
DATE OF INJURY _____	DATE OF INJURY _____
CLAIM NUMBER _____	ATTORNEY NAME _____
ATTORNEY NAME _____	ADDRESS _____
ADDRESS _____	CITY _____ STATE _____ ZIP _____
CITY _____ STATE _____ ZIP _____	PHONE _____
PHONE _____	AUTO INSURANCE _____

I, the undersigned, assign directly to Valley View Wellness Medical Center, all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the medical center to release all information necessary to secure payment of benefits.

Signature _____ Date _____

(If the patient is a minor, signature of parent or guardian authorizing treatment)
 Please notify us if any of the above information changes during the course of your treatment