a Division of BASS Medical Group

Joseph Rose MD Janine Senior MD Madhavi Vemulapalli MD Rusna Jhita MD Lauren Lockwood CNM
Anna Ameli WHNP Hope Rubin PA Lauren Abrahamson CNM Kaitlyn Routzen CNM

Name (Last, First, Middle) _____ Nickname _____ Pronouns _____

DOB _____ SSN _____ Email _____

Address: _____City: _____ State:_____ Zip: _____

Home # _____ Mobile #_____ Work # _____

Okay to leave a message or email? ☐Yes ☐No

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Domestic Partner

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Retired ☐Student Employer: _____

Referring Provider _____ PCP _____

Preferred Spoken Language _____ Preferred Written Language _____

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown ☐Decline to Disclose ☐Other_____

Race ☐American Indian/Alaskan ☐Asian ☐Black or African American ☐White or Caucasian ☐Decline to Disclose

Religion _____ ☐None ☐Decline to Disclose

Emergency Contact:

Name _____ Relationship _____ Phone #_____

Insurance Information

Primary Insurance Subscriber's Name _____ Subscriber's DOB _____

Subscriber's SSN _____ Relation to patient _____

Primary Insurance Subscriber's Name _____ Subscriber's DOB _____

Subscriber's SSN _____ Relation to patient _____

Patient/Guardian Signature: **Date:**

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Office and Financial Policies

To reduce any confusion or misunderstanding between our patients and RSVP, the following is our office and financial policies. We are committed to do our part to help keep healthcare affordable by minimizing unexpected expenses. By signing below, you acknowledge and agree to our office financial policies.

Copays/Deductibles:
Full payment is due at the time of service, unless you have made prior arrangements in advance. We accept Visa, MasterCard, American Express and Discover.
An e-visit will be billed to your insurance for electronic and/or over the phone visits.

Maternity Benefits:
After your Initial Prenatal visit, we call your insurance and check your maternity benefits. If a coinsurance applies, expecting parents will be responsible for the prepayment at each visit.

Medical Insurance:
It is your responsibility to provide our office with your current insurance information as well as your correct name, address, phone numbers. If you do not provide proper insurance at the time of service, you will be the responsible for the full payment. Please inform our office of any changes to your insurance prior to your next visit.

Billing:
We bill **participating** insurance companies. If your health plan determines that a service to be (not covered), you are financially responsible for any services provided, including any balances not covered by the insurance. Any questions regarding your bill, please contact our billing department at 925-627-3424.

Cancelling Appointments:
We request a 24-hour notice of cancellation of any appointment to accommodate our patients. If you fail to keep your appointment, there will be a cancellation charge of $50.00.

Prescription Refill Policy:
All prescriptions are done electronically through your pharmacy, or you may place a request via MyChart. RSVP will respond to all refill requests within 48 to 72 hours. The pharmacy could be backed up or delayed in responding to our request for you. We kindly ask that you do not wait until the last minute to request a refill on your medications.

Patient Signature: _____ **Date:** _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. Please review it carefully. We are required by law to:

- Maintain the privacy of protected health information.
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose health information that identifies your ("Health Information"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice's office manager.

TREATMENT We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Heath Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

PAYMENT We may use and disclose Health Information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

HEALTH CARE OPERATIONS We may use and disclose health information for health care operation purposes. These uses and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may also share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND HEALTH RELATED BENEFITS AND SERVICES We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We may also use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

(OVER)

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE When appropriate, we may share health information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

SPECIAL SITUATIONS

As required *by law* we will disclose health information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety we may use and disclose health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf, who are also obligated to protect the privacy of your information.

Organ and Tissue Donation If you are an organ donor, we may use or release health information to necessary organizations which are involved in procurement, banking, or transportation of such organs.

Military and Veterans If you are a member of the armed forces, National or Foreign, we may release health information as required by military command authorities.

Printed Name: _____ Date: _____

Patient Signature: _____

**If not signed by patient, please indicate relationship to patient:* _____

(OVER)

BASS
MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

☐ **OK to Spouse:** _____
☐ **OK to ALL family members: Please list names of family members:**
_____

☐ **OK to Other:** _____
☐ **OK to leave health information on answering machine or voice mail**

☐ **DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).**
☐ **DO NOT RELEASE TO**_____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jenny Aivazian, at **(925) 932-6330.**

This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:_____ Date:_____

Patient's Name:_____ Date of Birth:_____

If person signing is not patient please provide:
Name: _____

Relationship to patient: _____