ERIC N. SORENSEN M.D., INC.

1028 N. DOUTY ST.
HANFORD, CA 93230

TEL: 559-589-6420
FAX: 559-589-6425

NEW PATIENT QUESTIONNAIRE FORM

WE DO NOT ACCEPT MEDI-CAL

PATIENT FIRST NAME	INITIAL	LAST NAME	TODAY'S DATE:

HOME PHONE:	CELL PHONE:	WORK PHONE:	DATE OF BIRTH:

PREVIOUS DOCTOR(S):

REASON FOR LEAVING PREVIOUS DOCTOR:

MEDICAL HISTORY:

PLEASE LIST ALL MEDICATIONS:

CURRENT PREFERRED PHARMACY:

WHAT IS YOUR FIRST VISIT WITH DR. SORENSEN FOR?

Someone from our office will be contacting you after Dr. Sorensen has reviewed this information.

THANK YOU FOR YOUR TIME.

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PATIENT REGISTRATION FORM

PATIENT FIRST NAME | MIDDLE INITIAL | LAST NAME

STREET ADDRESS: | APT #: | CITY: | STATE: | ZIP:

HOME PHONE: | CELL PHONE: | WORK PHONE:

EMAIL ADDRESS: | SOCIAL SECURITY #: | DATE OF BIRTH: | AGE:

EMPLOYER:

SEX (CHECK ONE): ☐ MALE ☐ FEMALE

PATIENT SPOUSE INFORMATION

SPOUSE'S NAME: | DATE OF BIRTH:

EMPLOYER: | WORK/CELL PHONE:

PHARMACY INFORMATION

If you ever need a prescription called into a pharmacy from our office, we will need the name and the phone number of a pharmacy of your choice (if your pharmacy of choice changes, be sure to notify the staff when calling to request a prescription refill.

PHARMACY NAME: | PHARMACY PHONE:

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: | NAME OF PRIMARY INSURED:

PRIMARY INSURED'S DOB: | PRIMARY INSURED'S EMPLOYER:

PATIENT'S RELATIONSHIP TO THE PRIMARY INSURED IS: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

PLEASE COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

FATHER'S NAME: | DOB: | WORK PHONE #

MOTHER'S NAME: | DOB: | WORK PHONE #

IMPORTANT: LIST ALL ALLERGIES TO MEDICATIONS:

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

PLEASE CIRCLE YOUR RESPONSE TO THE FOLLOWING:

1. May we leave messages concerning your appointments with a co-worker, receptionist or secretary that regularly answers your calls? ☐ YES ☐ NO ☐ N/A

2. May we leave messages for you on a voice mail at work? ☐ YES ☐ NO ☐ N/A

3. If you are over the age of 18, and still living at home, may we discuss your appointments/treatments with your parent(s) or guardian? ☐ YES ☐ NO ☐ N/A

4. If you are over the age of 18, may we discuss your appointments and/or treatment with your children? ☐ YES ☐ NO ☐ N/A

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY:

By signing this registration form, I acknowledge receipt of Eric N. Sorensen M.D., Inc. Privacy Policy Notice. I understand my rights to privacy and know if I have any questions or specific requests that I may direct them to the Office Manager.

SIGNATURE: | DATE:

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PATIENT FIRST NAME	INITIAL	LAST NAME	DATE OF BIRTH:

PAYMENT POLICY FORM

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. We have developed this Payment Policy to clarify and answer questions regarding patient and insurance responsibility for services rendered. Please read it, and sign in the space provided. A copy will be provided to you upon request.

1. PAYMENTS
Balances due (including deductibles, nonpayments, unpaid co-pays, etc.) will be collected prior to being seen by a provider.

2. INSURANCE
Knowing your insurance benefits is your responsibility. We participate in most insurance plans. If you are insured by a plan that we do not participate in, payment in full is expected at each visit. If you are insured by a plan that we do participate in but don't have a current insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.

3. CO-PAYMENTS
All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. NON-COVERED SERVICES
Please be aware that services provided may not be covered by your insurance plan. You must pay for these services in full when you are billed the balance after your visit has been reviewed by your insurance company. You may appeal your claim with your insurance company.

5. PROOF OF INSURANCE
All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. CLAIMS SUBMISSION
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. COVERAGE CHARGES
If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

8. NONPAYMENT
If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:	DATE:

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PAYMENT POLICY FORM – PAGE 2

SELF PAY/ CASH PAY

Office Visit Only – First Visit: $95.00; Office visits after initial visit: $75.00

During your visit, if any additional testing or service is required there will be an additional fee in which that fee will be due at the time service is given.

MEDICARE

Medicare Without Secondary Coverage: Medicare is a health plan sponsored by the U.S. Government. It includes two components: Part A for Hospital Services and Part B for outpatient (non-hospital based) healthcare services. ***Eric N. Sorensen, M.D., Inc. accepts Medicare and is considered a Part B healthcare provider.*** Medicare Part B covers 80% of the cost allowed by Medicare for MBP services. The Medicare patient is responsible for the remaining 20% of the allowable amount.

For example: *If Medicare allows $100 for a visit with Dr. Sorensen or his physicians, Medicare would pay $80 and the patient would be required to pay $20 as coinsurance. Medicare Part B does not have an annual maximum out-of-pocket coinsurance amount. Our office provides the following options to handle financial responsibility.* ***Dr. Sorensen's office requires all Medicare co-insurance payments be made in advance of services provided. Payment can be by credit card, or cash.***

Medicare with Secondary Coverage: If the patient has secondary insurance, the remaining 20 percent of the allowable amount is paid by the secondary insurance plan.

For example: *If Medicare allows $100 for a visit with Dr. Sorensen or one of his physicians, Medicare would pay $80 and the patient's Secondary insurance would pay a portion of the remaining $20.00 owed to Eric N. Sorensen M.D., Inc.*

Our office provides patients with Medicare and a secondary insurance carrier with the following method to handle financial responsibility: Our office requires deductibles or co-insurance amounts for Medicare with secondary coverage plans to be paid within 30 days of receiving a statement from our billing department. Patients will receive an explanation of benefits from Medicare and the secondary insurance carrier and a statement from Dr. Sorensen's office, which will clearly list the amount owed for deductible or co-insurance. If the account goes unpaid, it will be sent to collections.

COMMERCIAL INSURANCE PLANS

Our office will verify health insurance benefits with your insurance carrier and will determine what amount, if any, you will owe. Commercial plans may include a deductible co-insurance, co-payments and authorizations that are required before care can be provided.

Deductibles and Co-insurance: Most commercial health insurance plans include an annual deductible amount and co-insurance. This is the subscriber's (i.e. patient) share of the cost the insurance company determined was required to provide coverage. Dr. Sorensen's office requires deductibles or co-insurance amounts be paid within 30 days of receiving a statement, Patients will receive an explanation of benefits from their insurance carrier and a statement from the office, which will clearly list the amount you owe for deductible or coinsurance. If your account has an overdue balance, you will be required to pay the full amount owed before further care is provided by Dr. Sorensen or any of his physicians.

Co-payments: Many health insurance plans require the subscriber (patient) to pay each time they receive a particular type of service from a doctor or hospital. Co-payments are often required for doctor office visits, diagnostic imaging services and laboratory services (i.e. blood work).

Eric N. Sorensen M.D., Inc. requires all co-payments be made in advance of services being provided. Payment can be by credit card or cash.

NO EXCEPTIONS – NO CHECKS FOR CO-PAYMENTS, ONLY FOR PAYMENTS FOR WHICH YOU'VE RECEIVED A BILL.

PATIENT SIGNATURE:

DATE:

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PATIENT FIRST NAME | INITIAL | LAST NAME | DATE OF BIRTH:

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Eric N. Sorensen M.D., Inc. Family Practice. When you schedule an appointment with Eric N. Sorensen M.D., Inc. Family Practice, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective June 14, 2018, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $45.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time with be charged a $65.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a third time will be charged for the full office visit fee of $95.00.
- If a fourth No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be dismissed from Eric N. Sorensen M.D., Inc. Family Practice.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect. Also, it is your responsibility to keep the office up to date with current contact information.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact Eric N. Sorensen M.D., Inc. Family Practice 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Eric N. Sorensen M.D., Inc. Family Practice: (559) 589-6420

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: | DATE:

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MEDICAL RELEASE FORM

PATIENT FIRST NAME | MIDDLE INITIAL | LAST NAME

STREET ADDRESS: | APT #: | CITY: | STATE: | ZIP:

PHONE NUMBER: | DATE OF BIRTH:

ERIC N. SORENSEN, M.D. INC. IS AUTHORIZED TO: (check one) ☐ SEND TO ☐ RECEIVE FROM

RECIPIENT / DISCLOSER:

STREET ADDRESS:

PHONE NUMBER: | FAX NUMBER:

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

☐ **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** including information and records (or copies of records) relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release **POTENTIALLY SENSITIVE INFORMATION** which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

☐ **I GIVE PERMISSION TO RELEASE ONLY RECORDS** specifically described below:

PATIENT SIGNATURE (PARENT'S REPRESENTATIVE IF MINOR) | DATE:

WITNESS SIGNATURE | DATE:

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HIPAA AUTHORIZATION FORM FOR FAMILY MEMBERS/FRIENDS

PATIENT'S NAME

I, _____ give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

LIST FRIENDS/FAMILY MEMBERS	RELATIONSHIP

HEALTH INFORMATION TO BE DISCLOSED (Check all that apply):

☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ My complete health record, as above with the exception of the following information (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify) _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options for treatment or consultation, for claims payment purposes, or related reasons.

THIS AUTHORIZATION SHALL BE EFFECTIVE UNTIL (check one):

- ☐ All past, present, and future periods, **OR**
- ☐ Date or event _____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

NAME OF THE INDIVIDUAL GIVING THIS AUTHORIZATION:

_____

SIGNATURE OF THE INDIVIDUAL GIVING THIS AUTHORIZATION:

_____

DATE:

_____

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HEALTH HISTORY QUESTIONNAIRE

DATE:

PATIENT FIRST NAME | INITIAL | LAST NAME | DATE OF BIRTH:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

ILLNESSES – Have you ever been diagnosed with any of the following illnesses or medical concerns? Check all that apply. If **YES,** include the approximate date or year.

CHECK	CONDITION	APPROX. DATE/YEAR
	Abdominal Aortic Aneurysm	
	Alzheimer's Disease	
	Anemia	
	Angina	
	Asthma / Bronchitis	
	Bladder Cancer	
	Breast Cancer	
	Cardiac Arrhythmia	
	Cerebrovascular Accident (Stroke)	
	Cervical Cancer	
	Cholelithiasis	
	Colon Cancer	
	Coronary Artery Disease	
	Cystocele / Rectocele	
	Deep Venous Thrombosis	
	Depression	
	Diabetes	
	Diverticulosis / Diverticulitis	

CHECK	CONDITION	APPROX. DATE/YEAR
	Emphysema	
	Erectile Dysfunction (ED)	
	Genital Condyloma	
	Genital Herpes	
	Glaucoma	
	Gout	
	Heart Attack	
	Heart Failure	
	Heart Murmur	
	Hepatitis	
	Hiatal Hernia	
	High Blood Pressure	
	HIV/AIDS	
	Hodgkin's Disease	
	Kidney Cancer	
	Kidney Stones	
	Leukemia	
	Lung Cancer	
	Malignant Lymphoma	

CHECK	CONDITION	APPROX. DATE/YEAR
	Mitral Valve Prolapse	
	Multiple Sclerosis	
	Osteoarthritis	
	Ovarian Cancer	
	Padgett's Disease	
	Parkinson's Disease	
	Penile Cancer	
	Prostrate Cancer	
	Prostrate Enlargement (BPH)	
	Prostatitis	
	Pulmonary Tuberculosis	
	Seizures	
	Testis Cancer	
	Thyroid Disease	
	Transient Ischemic Attack (TIA)	
	Ulcerative Colitis	
	Urinary Incontinence	
	Urinary Tract Infection	

OPERATIONS – Please list all surgeries including the approximate date and year.

SURGERY	DIAGNOSIS	DATE/YEAR

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HEALTH HISTORY QUESTIONNAIRE – PAGE 2

MEDICATIONS – Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date/year.

NAME OF DRUG	STRENGTH	FREQUENCY TAKEN	START DATE/YEAR

ALLERGIES – Please list all drug allergies including type of reaction.

NAME OF DRUG	TYPE OF REACTION

PERSONAL HISTORY AND HEALTH HABITS

MARITAL STATUS	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow		
RELIGION (List)			
OCCUPATION (List)			
ADVANCE DIRECTIVE	☐ None ☐ Living Will ☐ Surrogate		
PHYSICAL ACTIVITY	☐ Non-Ambulatory ☐ Inactive ☐ Running ☐ Strength Training ☐ Yoga ☐ Limited Mobility ☐ Walking ☐ Swimming ☐ Aerobic Training ☐ Recreational Activities		
DIETARY	☐ Regular ☐ Vegetarian ☐ Lactose Free ☐ Keto ☐ Weight Gain ☐ Low Fat ☐ Diabetic ☐ Gluten Free ☐ Weight Reduction ☐ Renal Failure		
ALCOHOL	Beer (drinks/week) Wine (drinks/week) Liquor (drinks/week)	Duration: _____ years Duration: _____ years Duration: _____ years	Date Discontinued: _____ Date Discontinued: _____ Date Discontinued: _____
TOBACCO	Cigarettes (pks/day) Cigar (#/day) Pipe (#/day) Chew (#/day) Snuff (#/day)	Duration: _____ years Duration: _____ years Duration: _____ years Duration: _____ years Duration: _____ years	Date Discontinued: _____ Date Discontinued: _____ Date Discontinued: _____ Date Discontinued: _____ Date Discontinued: _____
DRUGS	Marijuana (#/day) Cocaine (#/day) Other (#/day)	Duration: _____ years Duration: _____ years Duration: _____ years	Date Discontinued: _____ Date Discontinued: _____ Date Discontinued: _____

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HEALTH HISTORY QUESTIONNAIRE – PAGE 3

FAMILY HEALTH HISTORY

☐ No History or Familial Disease

RELATION (i.e. Father, Mother, Uncle, Sister, etc.)	ILLNESS (i.e. Diabetes, Heart Disease, Prostrate Cancer, etc.)

REVIEW OF SYSTEMS – Check all that apply.

	CHECK	SYMPTOM	CHECK	SYMPTOM	CHECK	SYMPTOM	CHECK	SYMPTOM
GENERAL		Anorexia		Chills		Fatigue		Fever
		Malaise		Sweats		Weight Loss		
EYES		Blurred Vision		Double Vision		Eye Pain		
		Eye Discharge		Vision Loss		Eye Irritation		
EAR, NOSE, THROAT		Decreased Hearing		Ringing in Ears		Ear Pain		
		Hoarseness		Pain with Swallowing		Nose Bleeds		
CARDIOVASCULAR		Chest Pain		Peripheral Edema		Palpitations		
RESPIRATORY		Cough		Wheezing		Bloody Sputum		Shortness of Breath
GASTROINTESTINAL		Abdominal Pain		Nausea		Vomiting		Diarrhea
		Constipation		Tarry Stools		Bloody Stools		
GENITOURINARY		Painful Urination		Blood in Urine		Sexual Dysfunction		
		Difficulty Voiding		Urinary Incontinence				
MUSCULOSKELETAL		Back Pain		Joint Pain		Joint Swelling		Muscle Weakness
SKIN		Dryness		Itching		Rash		Suspicious Lesion
NEUROLOGICAL		Dizziness		Weakness		Tremors		Seizures
PSYCHIATRIC		Depression		Anxiety		Memory Loss		Hallucinations
ENDOCRINE		Cold Tolerance		Heat Tolerance		Increased Thirst		Weight Change
HEMATOLOGICAL & LYMPHATIC		Abnormal Bruising		Easy Bleeding		Enlarged Lymph Nodes		
ALLERGY & IMMUNOLOGIC		Hay Fever		Itching		HIV Exposure		

CERTIFICATION – The above information is true to the best of my knowledge.

SIGNATURE OF PATIENT/LEGAL GUARDIAN/AUTHORIZED PERSON

DATE OF SIGNATURE