Inland Physicians
Medical Group

9525 Monte Vista Ave St #105, Montclair CA 91763
637 N 13th Ave Upland CA 91786
www.inlandphysiciansmg.com

Dear Sir or Madam,

Welcome to Inland Physicians Medical Group. We are a division specializing in internal medicine, pulmonary disease, critical care, sleep disorder, and pulmonary rehabilitation, located in the Inland Empire region.

You have an appointment scheduled with Dr. _____

On _____ at _____ am / pm

in our _____Office. If this is not correct, please call the office.

In order to make your appointment run more smoothly, please bring/fill out the following:

- **FORMS:** Please fill out the enclosed forms and return to our office prior to your scheduled appointment. These forms can also be downloaded from our website at www.inlandphysiciansmg.com
- **INSURANCE CARD:** (primary or secondary cards). We will need to make copies of your cards.
- **TEST RESULTS:** (blood work, biopsy, sleep study, MRI, CT, X-Ray, Ultrasound, PET scan…). We may not be able to get these results the day of your appointment so please get copies of these ahead of time from your primary care physician or the facility where the test was performed.
- **FILMS:** In addition to the reports, you MUST bring in the actual films or a disk (CD-ROM) of the imaging study for the doctor to review as well.
- **CO-PAYs:** (HMO's and other insurances that require a co-pay). All Co-Pays must be paid at the time of your visit. There will be an additional processing charge for any Co-Pay billing.
- **REFERRALS:** Please ensure that your referral (if required by your insurance plan) has been obtained or put into the system by your primary care physician's office before your appointment. If you do not have a referral on the day of your appointment, it may be rescheduled.
- **MEDICATIONS:** Please bring in a complete list of current medications.

Please be aware that it is your responsibility to know the terms of your insurance contract. We participate with numerous of insurance plans, which have very different policies. Our office staff cannot be responsible for knowing your specific plan's policies.

Please keep in mind that you will be responsible to furnish all necessary information for the physician to review at the time of your visit, without this information your appointment may be cancelled and/or rescheduled for a later date. **Please arrive 10/15 minutes prior to your schedule appointment.**

NEW PATIENT INFORMATION

Patient Name: DOB:

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Last Name_____ **First Name** _____ **M.I.** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Soc. Sec. # _____ **Age** _____ **DOB** _____ **Phone #** _____

CA DL# _____ **Marital Status:** ❑ Married ❑Widow ❑ Divorce ❑ Single ❑Separated ❑Dating

Gender: ❑ Male❑ Female Race: _____ **Religion**: _____

Ethnicity: _____ **Preferred Language:** _____ ❑ **Refused** ❑ **Decline**

Preferred Pharmacy Name/Address: _____

Employer _____ **Occupation** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

PRIMARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

SECONDARY INSURANCE
Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name _____ **Phone #** _____

DOB _____ **Soc. Sec. #** _____ **Relation** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Ins. Co. Name _____ **Policy #** _____ **Phone #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

EMERGENCY CONTACT:

Name _____ **Relation**: _____ **Phone #** _____

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Financial Policy

All Patients: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payment rests with you, the patient or responsible party.

Cash Patients: All services rendered on a cash basis must be paid in full at the time of service.

Private Insurance: We must have a fully completed and signed insurance form at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Deductible and co-payment amounts are due at the time of service.

Medicare: We must have a copy of your Medicare card and any secondary insurance(s). We do accept assignment on Medicare claims, which means that you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies, which are NON-COVERED services for Medicare patients. If you need such services you will be informed that they are NON-COVERED and if you still wish to receive such services in this office they will be on a cash basis at the time of service.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, A 24-HOUR NOTICE IS ABSOLUTELY MANDATORY. SHOULD YOU FAIL TO DO SO, YOU WILL BE CHARGED A $35 CANCELLATION FEE FOR NEW PATIENTS /$25 CANCELLATION FEE FOR ESTABLISHED PATIENTS. A $25 NO-SHOW FEE FOR ESTABLISHED PATIENTS/ $50 NO SHOW FOR NEW PATIENTS. A $25 NO-SHOW FEE FOR TELEHEALTH ESTABLISHED PATIENTS/ $25 NO SHOW FOR TELEHEALTH NEW PATIENTS. A $175 CANCELLATION FEE / $300.00 NO SHOW FEE FOR SLEEP STUDIES, UNLESS A 48 HOUR NOTICE IS GIVEN. A $75 CANCELLATION / $75 NO-SHOW FEE FOR PFT. ALL FEES WILL BE DIRECTLY BILLED TO YOU, THE PATIENT. HEALTH INSURANCES DO NOT COVER THIS EXPENSE. PLEASE CONTACT OUR OFFICE TO INFORM OUR STAFF OF ANY CHANGES.

IF AT ANY TIME YOU SHOULD EXPERIENCE FINANCIAL HARDSHIP, PLEASE MAKE OUR OFFICE AWARE OF THE SITUATION. WE ARE ALWAYS WILLING TO MAKE SPECIAL ARRANGEMENTS FOR THOSE PATIENTS WHO NEED EXTRA HELP. IF YOU NEED TO MAKE ARRANGEMENTS, PLEASE ASK TO SPEAK WITH THE OFFICE MANAGER.

Financial Agreement: I, the undersigned, hereby authorize you to make payments directly to Inland Physicians Medical Group for all basic and major medical expenses. I fully understand that I am financially responsible for any balance.
Medical Records: I, the undersigned, hereby grant authorization for the release of any information required to process the medical claims. A copy of this authorization is as valid as the original.
Consent for Treatment: I, the undersigned, hereby consent to the administrator of and performance of all diagnostic procedures and treatment, which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, the physician will not be liable for the consequences of such decision.

I have carefully read and understand all of the above and accept, approve, and agree to **Inland Physicians Medical Group** *Office Financial Policy*.

_____ _____

Patient or Responsible Party Signature **Date**

Patient Name: DOB:

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CHIEF COMPLAINT/ REASON FOR TODAY'S VISIT:

_____
_____
_____
_____

PATIENT MEDICAL HISTORY

ALLERGIES:

_____

SURGICAL HISTORY:

_____

PAST MEDICAL HISTORY:

Major Illness/Date of Onset: _____

_____

Positive for TB:	❑ Yes	❑No	Date of Onset: _____
Do you snore?	❑ Yes	❑No	Date of Onset: _____
Are you excessively tired during the day?	❑ Yes	❑No	Date of Onset: _____
Have you been told you stop breathing during sleep?	❑ Yes	❑No	Date of Onset: _____
Do you have history of hypertension?	❑ Yes	❑No	Date of Onset: _____
Is you neck size >17in (male) or >16in (female)?	❑ Yes	❑No	Date of Onset: _____

FAMILY HISTORY:

Lung Disease	❑ Yes	❑No	Who? _____ Age of Onset: _____
Heart Disease	❑ Yes	❑No	Who? _____ Age of Onset: _____
Diabetes	❑ Yes	❑No	Who? _____ Age of Onset: _____
Cancer	❑ Yes	❑No	Who? _____ Age of Onset: _____
Cancer Type: _____			
Blood Pressure	❑ Yes	❑No	Who? _____ Age of Onset: _____
Positive TB	❑ Yes	❑No	Who? _____ Age of Onset: _____

TOBACCO USE: Smoke Cigarettes: ❑ Yes ❑No Quit: If so, when? _____
❑Never ❑Yes ❑No Quit Date: _____ How Long: _____ # Packs: _____ # Cigs: _____

OTHER TOBACCO:

Cigar	❑Never ❑Yes ❑No Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Pipe	❑Never ❑Yes ❑No Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Snuff	❑Never ❑Yes ❑No Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____
Chew	❑Never ❑Yes ❑No Quit Date: _____	How Long: _____	# Packs: _____	# Cigs: _____

ALCOHOL USE: ❑Yes ❑No Quit Date: _____ **How often**: ❑ Daily ❑ Frequently ❑ Social ❑ Rarely

DRUG USE:

Do you use marijuana or recreational drugs? ❑Yes ❑No Type: _____
Have you ever used needles to inject drugs? ❑Yes ❑No Type: _____

PLEASE LIST ANY PRIOR (*MOST RECENT*) HOSPITALIZATIONS: _____

REFERRING PHYSICIAN: _____

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CURRENT MEDICATION RECORD

MEDICATIONS: Please list all medications you currently take, including appetite suppressants, vitamins, etc.

MEDICATION NAME	STRENGTH	FREQUENCY	START/END DATE	PRESCRIBING PHYSICIAN	DISPENSING PHARMACY

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Epworth Sleepiness Scale

Date____/____/_____

Take a moment to think about day-to-day life over the past few weeks. How likely are you to doze off or fall asleep verses just feeling tired while participating in a situation that requires your attention, such as driving, reading, or attending a meeting?

The *Epworth Sleepiness Scale* presents various daily situations and asks you to rate your degree of sleepiness in each circumstance. Even if you have not done some of these things recently, try to think about how they would affect you.

Use the following scale to choose the most appropriate number for each situation:

0 = ***no chance*** of dozing
1= ***slight*** chance
2 = ***moderate*** chance
3 = ***high*** chance

Situation	**Chance of dozing (0 – 3)**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g., theater or meeting)	0	1	2	3
As a passenger in car for 1 hour with no break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopping for a few minutes in traffic	0	1	2	3

Total Score____

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Notice of Privacy Practice

I hereby understand that I may receive a copy of the medical practice's Notice of Privacy Practices upon my request. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Patient Name: DOB:

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that applies):

- ❑ Home Telephone No. _____
  - ❑ Acceptable to leave message with detailed information.
  - ❑ Leave message with call back number only.
- ❑ Work Telephone No. _____
  - ❑ Acceptable to leave message with detailed information.
  - ❑ Leave message with call back number only.
- ❑ Written Communication
  - ❑ Acceptable to mail to my home address.
  - ❑ Acceptable to mail to my work/office address.
  - ❑ Acceptable to fax to this number _____
- ❑ Other _____
  _____

I authorize Inland Physicians Medical Group physicians and/or staff to disclose *PHI* to the following members of my family or person/s responsible for my healthcare (check all that apply):

- ❑ Spouse: Name _____
- ❑ Daughter/s: Name/s _____
- ❑ Son/s: Name/s _____
- ❑ Extended Care Facility _____
- ❑ Other: _____
  _____

_____ _____

Print Name **Date of Birth**

_____ _____

Patient Signature **Date**

Patient Name: DOB:

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Request for Release of Medical Records

PLEASE RELEASE RECORDS TO:

❒ Inland Physicians Medical Group
9655 Monte Vista Avenue, Suite 402
Montclair, CA 91763
Phone: (909) 626-1205
Fax: (909) 625-1977

❒ Inland Physicians Medical Group
637 N. 13th Avenue
Upland, CA 91786
Phone: (909) 985-9321
Fax: (909) 985-0842

❒ _____
_____
_____
Phone No. _____
Fax No. _____

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

❒ Consultation
❒ History and Physical
❒ Progress Notes
❒ Treadmill Test
❒ Holter
❒ EKG
❒ Laboratory
❒ Pulmonary Function Test
❒ X-Ray
❒ CT scan
❒ PET scan
❒ Any and all Radiology

Other: _____

Date: _____

Patient Signature: _____

Patient Name: DOB: