# Primary CARE Consultants, Inc A Medical Group

**DEMOGRAPHIC FORM**

Name: (Last, First, MI): _____ ☐ Jr. ☐ Sr.
Date of Birth: _____ Marital Status:
Language Preference: _____ Ethnicity: _____ Race: _____
Address: _____ Apt.#: _____
City/State/Zip: _____ Social Security #: _____
Employer Name: _____ Employer Phone: _____
Home Phone: _____ Cell Phone. _____
Email Address: _____

***Can we e-mail you appointment reminders and an invitation to our patient portal?*** ☐ YES ☐ NO

**GUARANTOR INFORMATION - ☐ Check here if same as patient**

Responsible Party: _____ Date of Birth: _____
Address: _____
Home Phone: _____ Cell Phone: _____

**PRIMARY INSURANCE:** _____
**Patient's relationship to subscriber:** ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Subscriber Name: _____ Subscriber ID: _____
Subscriber's Social Security #: _____ Group #: _____
Subscriber Date of Birth: _____

**SECONDARY INSURANCE:** _____
**Patient's relationship to subscriber:** ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
Subscriber Name: _____ Subscriber ID: _____
Subscriber's Social Security #: _____ Group #: _____
Subscriber Date of Birth: _____

**EMERGENCY CONTACTS:**

Name: _____ Relationship to patient: _____ Phone Number: _____

Name: _____ Relationship to patient: _____ Phone Number: _____

I am aware that if the above information is not true or if there is no coverage for the services I receive, I (or person financially responsible for me) will remain responsible for payment of all amounts owed. I understand that it is my responsibility, to notify the billing office (559) 297-1322 of any changes in my insurance or my plan benefits. I hereby authorize the office of Primary Care Consultants, Inc to furnish to my insurance company any and all information requested by said insurance company for payment of submitted charges, which are to be released directly to Primary Care Consultants. It is not the responsibility of Primary Care Consultants to know what your benefits cover. _____ **INITIAL**

I hereby consent to examination and treatment by the physicians, licensed physician assistants and/or nurse practitioners associated with Primary Care Consultants, Inc. I also give consent for Primary Care Consultants providers to discuss my medication history with any pharmacies/pharmacist that the provider deems necessary _____ **INITIAL**

Primary Care Consultants uses Quest Diagnostics Lab and Lab-Corp for labs, pap smears and cultures. If your insurance requires you to use a specific facility, please list: _____. If left blank, we will use the above specific facilities. _____ **INITIAL**

Agreement to electronic communication of patient information with other treating providers and registries for purposes of care coordination; discussion about what chronic care management services are and how they are accessed; details about how patient information will be shared with providers on the care team; communication that cost-sharing applies to these services even when they are not provided face-to-face._____ **INITIAL**

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

# Primary CARE Consultants, Inc A Medical Group

## PATIENT FINANCIAL POLICY AGREEMENT

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____

**PRIMARY INSURANCE:** _____

**SECONDARY INSURANCE:** _____

**INSURANCE:**

- It is your responsibility to supply Primary Care Consultants with the appropriate billing information. This includes current identification as well as the billing address and anything else required by your insurance carrier for payment of claims.
- Your insurance policy is a contract between you and your insurance company. If we are contracted with your insurance company, we must follow our contract and their requirements.
- As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable time, we will have to look to you for payment. Please note that it is the insurance company that makes the final determination of your eligibility
- If you have a secondary insurance we will make two attempts to bill them. If no payment is received you will be responsible for the balance.
- Please keep in mind that all health plans are not the same and do not cover same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Please be aware that some procedures, and some services provided may not be covered by your insurance. It is your responsibility as the patient, to understand your insurance plan.

**CO-PAYS:**

- **Co-pays are due at the time of service.** We cannot waive or discount this fee due to our contracts with insurance companies. If not paid, we reserve the right to charge a $10.00 service fee. The balance is your responsibility whether your insurance company pays or not.

**DEDUCTIBLES:**

- For all high deductible plans, we collect $100.00 towards deductibles at the time of services.

**MEDICARE PATIENTS :**

- Primary Care Consultants will bill Medicare for you. We will also bill any secondary insurance you may have. All deductibles or payments of non-covered services are due at the time services are rendered.

**SELF-PAY FINANCIAL POLICY :**

- If you are uninsured and are in need of treatment, we can see you on a self-pay basis. Our goal is to provide you with affordable health care. **A $100.00 deposit is required for ESTABLISHED patients and $150.00 deposit is required for NEW patients at the time of service.** Each visit can vary in price depending on what services are rendered. We do not give quotes or prices prior to a patient being seen. (Note: We **DO NOT accept checks from new patients on the 1st visit only;** you must pay with credit/debit, money order or cash). **THIS IS A DEPOSIT ONLY, NOT PAYMENT IN FULL. WE WILL NOT KNOW HOW MUCH YOUR SERVICE WILL BE UNTIL AFTER YOU ARE SEEN.**
- 
- Outstanding balances on accounts over $100.00 must be paid in three months or the account will be forwarded to an outside collection agency and may result in dismissal from our practice. _____ **SELF-PAY INITIAL(ONLY)**

**STATEMENTS**

- Your insurance will determine total payment due to the doctor, pay the customary amount and notify our office of the deductible and/or co-insurance amount. We will then bill you for the allowable fees due and request that you promptly remit payment to our office. Unless other arrangements have been made in advance or in writing, the balance on your statement is due when the statement is issued, and is past due if not paid within 30 day from the issue date.
- 

**NO SHOW FEE & RETURNED CHECKS**

- There is a fee of $20.00 for any appointments not canceled within 24 hours of your scheduled appointment. There will be a $25 fee for checks returned by the bank.

**MINOR PATIENTS**

- For all services rendered to minor patients, we will look to the parent or guardian with custody for payment.

***I have read or have had read to me and understand the financial policy of the Primary Care Consultants. I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.***

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

# Primary CARE Consultants, Inc A Medical Group

Sharnjit Purewal, MD - Jaskeerit Purewal, MD
Jennifer Roberts, FNP—Gurmit Deol, NP—Michael Lemus, PA-C- Varinder Kaur, NP

**PRIVACY POLICY AGREEMENT**

I, _____ have received a copy of the **Notice of Privacy Practices from Primary Care Consultants, Inc., a Medical Group.** This notice includes a list of providers covered by the Privacy Practices. This notice is a pledge to protect medical information, how medical information may be used or disclosed, patient rights regarding their medical information, how to register a complaint about privacy issues and informs patients of their right to privacy.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

## PATIENT PORTAL INVITATION REQUEST

website at www.primarycareconsultants.com

I, _____ would like to receive an invitation to the **Primary Care Consultants, Inc., a Medical Group** patient portal. Please provide email address below. Once we receive your email address, we will send you an electronic invitation to sign up for our patient portal. To find out more information about our patient portal, you can visit our website at listed above. With our patient portal, you can manage your health anywhere, anytime.

**EMAIL ADDRESS:** _____

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

## CODE OF CONDUCT POLICY

Our practice believes in mutual respect to and from our patients, therefore we have enforced a **ZERO TOLERANCE POLICY AGAINST ANY VERBAL OR PHYSICAL ABUSE TO OUR PHYSICIANS AND/OR TO OUR STAFF MEMBERS.** Any form of such abuse or violence will result in immediate dismissal from the practice. I have read and understand **Primary Care Consultants, Inc., a Medical Group. Code of Conduct Policy** and agree to the terms specified. I also acknowledge that if requested, I am welcome to a copy of the signed policy.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

## CONSENT FOR TELEMEDICINE

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

I understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my medical care. I authorize **Primary Care Consultants, Inc., a Medical Group** to use telemedicine in the course of my diagnosis and treatment.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE

# Primary CARE Consultants, Inc A Medical Group

## MEDICAL HISTORY FORM (Page 1)

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____ **Date:** _____

**Reason you are seeing the doctor today?** _____

_____

_____

_____

### Disease Prevention and Health Maintenance

***Please list below the most recent dates of your vaccines and health screening tests***

| | Month/Year | | Month/Year | | Month/Year |
|---|---|---|---|---|---|
| Flu Vaccine | | Hepatitis B Vaccine | | Colonoscopy | |
| Pneumonia Vaccine 13 | | Mammogram | | EKG | |
| Pneumonia Vaccine 23 | | Pap Smear | | Heart Stress Test | |
| Tetanus/Tdap Vaccine | | Bone Density | | Heart Catheterization | |
| Shingles Vaccine | | Eye Exam | | Abdominal Aneurysm Screening | |

### Negative Medication Reactions or Food Allergies or Intolerances

***List below medications or foods causing an allergic reaction (Example: rash, swelling) or intolerance (Example: nausea)***

| Medication/Food | Reaction | Medication/Food | Reaction |
|---|---|---|---|
| | | | |
| | | | |

### Medications, Vitamins and Herbal Supplements

| Medication | Strength | Number of pills taken & frequency | Medication | Strength | Number of pills taken & frequency |
|---|---|---|---|---|---|
| *Example: Tylenol* | *500 mg* | *1– twice daily* | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

### Past Medical History

| Condition/Disease | Year Began | Condition/Disease | Year Began |
|---|---|---|---|
| ☐ Hypertension | | ☐ Other(s): | |
| ☐ High Cholesterol | | ☐ | |
| ☐ Hypothyroidism (low thyroid) | | ☐ | |
| ☐ COPD, Emphysema or Asthma | | ☐ | |
| ☐ Diabetes | | ☐ | |
| ☐ Heartburn/Reflux | | ☐ | |
| ☐ Depression or Anxiety | | ☐ | |
| ☐ Heart Problems | | ☐ | |

# Primary CARE Consultants, Inc A Medical Group

## MEDICAL HISTORY FORM (Page 2)

### Other Physicians and Specialists

***List below your other physicians***

***(Example: Gynecologist, Dermatologist, Gastroenterologist, Orthopedics, Urologist, Psychiatrist, etc.)***

| Name | Specialty | Diagnosis |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

### Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

| Operation/Hospitalization/ Injury | Month/Year | Operation/Hospitalization/ Injury | Month/Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### Family Health History

***Please list below the health history of your blood (genetic) first degree relatives.***

| Relative | Living or Deceased | Current age or age at death | Cause of Death | Health Problems |
|---|---|---|---|---|
| Father: | | | | |
| Mother: | | | | |
| Brother(s): | | | | |
| | | | | |
| | | | | |
| Sister(s): | | | | |
| | | | | |
| | | | | |

### Social, Education and Work History

| | | |
|---|---|---|
| Marital Status: | Spouse's Name: | Number of Children, if any: |
| Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled | Current or Prior Occupation: | Highest Level of Education: |
| Do you exercise regularly? ☐ YES ☐ NO | What type of exercises do you perform? Duration and Frequency? | |
| Do you have an Advanced health care directive? ☐ YES ☐ NO | In what type of residence do you live? *(e.g. house, assisted living, nursing home etc.)* | |
| What are your hobbies? | | |
| Do you drink alcohol? ☐ YES ☐ NO | If yes, what type of alcohol? | Number of drinks per week? |
| Any current tobacco use? ☐ YES ☐ NO | ☐ Cigarettes ☐ Cigar ☐ Vaping ☐ Chew | Packs per day? |
| Are you a former smoker? ☐ YES ☐ NO | If so, what year did you quit? | Number of years you smoked? |
| If female, number of Pregnancies: Miscarriages: Abortions: Live Births: | | |
| Are you sexually active? ☐ Yes ☐ No ☐ Not currently ☐ Never | Do you have sex with: ☐ Men ☐ Women ☐ Both | How many partners have you had during the past 12 months? |
| What do you use for birth control? | | |

# Primary CARE Consultants, Inc. A Medical Group
# REVIEW OF SYSTEMS

**NAME**_____ **DOB**_____ **DATE:**_____

## Please mark the symptom(s) or condition(s) YOU HAVE FOR TODAY'S VISIT :

**Constitutional**
- ☐ fever
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss
- ☐ exercise intolerance
- ☐ sedation
- ☐ lethargy
- ☐ chills
- ☐ malaise
- ☐ fatigue

**Eyes**
- ☐ wears glasses/contact lenses
- ☐ dry eyes
- ☐ irritation
- ☐ vision change
- ☐ eye disease/injury

**ENM (Ears/Nose/Mouth)**

***Ears***
- ☐ difficulty hearing
- ☐ ear pain

***Nose***
- ☐ frequent nosebleed
- ☐ nose problems
- ☐ sinus problems

***Mouth***
- ☐ sore throat
- ☐ bleeding gums
- ☐ snoring
- ☐ dry mouth
- ☐ oral abnormalities
- ☐ mouth ulcer
- ☐ teeth abnormalities
- ☐ mouth breathing
- ☐ ringing in the ears

**Cardiovascular**
- ☐ chest pain on exertion
- ☐ arm pain on exertion
- ☐ shortness of breath when walking
- ☐ shortness of breath when lying down
- ☐ heart pounding
- ☐ known heart murmur
- ☐ light-headed on standing
- ☐ ankle swelling

**Respiratory**
- ☐ cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ coughing up blood
- ☐ sleep apnea

**Gastrointestinal**
- ☐ abdominal pain
- ☐ nausea
- ☐ vomiting
- ☐ constipation
- ☐ change in appetite
- ☐ black or tarry stools
- ☐ frequent diarrhea
- ☐ vomiting blood
- ☐ indigestion
- ☐ acid reflux

**Genitourinary**
- ☐ urinary loss of control
- ☐ difficulty urinating
- ☐ Increased urinary frequency
- ☐ blood in urine
- ☐ incomplete emptying
- ☐ decreased libido
- ☐ erectile dysfunction
- ☐ night time urination

**Musculoskeletal**
- ☐ muscle aches
- ☐ muscle weakness
- ☐ arthralgias/joint pain
- ☐ back pain
- ☐ swelling in the extremities
- ☐ neck pain
- ☐ difficulty walking
- ☐ cramps
- ☐ thinning of bones
- ☐ fractures

**Integumentary (Skin)**
- ☐ abnormal mole
- ☐ jaundice
- ☐ rash
- ☐ itching
- ☐ dry skin
- ☐ growths/lesions
- ☐ laceration
- ☐ non-healing areas
- ☐ changes in hair/nails
- ☐ psoriasis
- ☐ change in skin color
- ☐ breast lump

**Neurologic**
- ☐ loss of consciousness
- ☐ weakness
- ☐ numbness
- ☐ seizures
- ☐ dizziness
- ☐ frequent or severe headache
- ☐ migraines
- ☐ restless legs
- ☐ tremor
- ☐ gait dysfunction
- ☐ paralysis

**Psychiatric**
- ☐ depression
- ☐ sleep disturbances
- ☐ feeling unsafe in relationship
- ☐ restless sleep
- ☐ alcohol abuse
- ☐ anxiety
- ☐ hallucinations
- ☐ suicidal thoughts
- ☐ mood swings
- ☐ memory loss
- ☐ agitation
- ☐ not functioning independently
- ☐ confusion

**Endocrine**
- ☐ fatigue
- ☐ increased thirst
- ☐ hair loss
- ☐ increased hair growth
- ☐ cold intolerance
- ☐ heat intolerance

**Hematologic/Lymphatic**
- ☐ swollen glands
- ☐ easy bruising
- ☐ excessive bleeding
- ☐ anemia
- ☐ pain in veins

**Allergic/Immunologic**
- ☐ runny nose
- ☐ sinus pressure
- ☐ itching
- ☐ hives
- ☐ frequent sneezing

☐ **OTHER**_____

# Primary CARE Consultants, Inc A Medical Group

## RELEASE OF INFORMATION

***Privacy release of any information to: Patients spouse, relative, friend, etc.***

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____ **Date:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2.The following individual or organization is authorized to make the disclosure:

**PRIMARY CARE CONSULTANTS, INC.**
**255 W. Bullard Ave. #124,**
**Clovis, CA 93612**
**Tel: (559) 297-1300 Fax: (559) 297-8379**

3. Any health information may be disclosed to the name (s) listed below.

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**5. This information may be disclosed to and used by the following individual (s):**

1. _____
2. _____
3. _____

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the release of information, as provided in CFR 165.524. I understand any disclosure of this information carries with it potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

8. If I have questions about disclosure of my health information, I can contact Medical Records Dept at (559) 297-1300 Ext: 238 or Privacy Officer at Ext: 262.

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

_____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATION TO PATIENT WITNESS

# Primary CARE Consultants, Inc A Medical Group

Sharnjit Purewal, MD - Jaskeerite Purewal, MD
Jennifer Roberts, FNP—Gurmit Deol, NP—Michael Lemus, PA-C- Varinder Kaur, NP

## INFORMED CONSENT FOR TELEMEDICINE SERVICES

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- ☐ Patient medical records
- ☐ Medical images
- ☐ Live two-way audio and video
- ☐ Outpatient data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Telemedicine can improve access to medical care by enabling a patient to remain in their remote site while the physician obtains test results and consults from healthcare practitioners at distant/other sites.

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:
☐ In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images).
☐ Delays in medical evaluation and treatment could occur due to failures of the equipment.
☐ In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:
☐ I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
☐ I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
☐ I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
☐ I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners within my family practice who may be located in other areas

I understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my medical care. I authorize **Primary Care Consultants, Inc., a Medical Group** to use telemedicine in the course of my diagnosis and treatment.

_____ _____
PATIENT NAME (print) DATE

_____ _____
PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE DATE