



Rocklin Family Practice & Sports Medicine

Roy Harris, M.D. • Kuo Ooi, M.D. • Julie Wei-Shatzel, D.O. • Biljinder Chima, M.D.

Patient Name: _____ Sex: M F Date of Birth: _____
First Middle Last

Social Security: _____ Email Address: _____

Race: _____ Ethnicity: Hispanic Non-Hispanic Decline to State Preferred Language: _____

Mailing Address: _____ City _____ State _____ Zip _____

Home Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Employer: _____ Occupation: _____

Employer Address: _____ City _____ State _____ Zip _____

Spouse's Name: _____ Social Security: _____ DOB: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Immediate family members living with you: _____

EMERGENCY CONTACT

Nearest relative not living with you: _____ Relation: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

RESPONSIBLE PARTY – If patient is a minor please name parent or guardian

Name: _____ Social Security: _____ DOB: _____
(Use name of legally responsible person)

Mailing Address: _____ City _____ Zip _____

Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____

MEDICAL INSURANCE

WE BILL INSURANCE COMPANIES WITH WHICH ROY M. HARRIS M.D., INC. IS CONTRACTED, OTHER WISE PAYMENT IS DUE AT THE TIME OF SERVICE.

Insurance Company: _____ Subscriber's Name: _____

I.D. #: _____ Group #: _____ Subscriber's DOB: _____

PATIENT OR AUTHORIZED PERSON SIGNATURE:

- I authorize all medical treatment as deemed necessary by Roy M. Harris M.D., Inc. and affiliated providers.
- I authorize release of any medical or other information necessary to process claims.
- I authorize my insurance carrier to make payment directly to Roy M. Harris M.D., Inc. for any medical services rendered.
- I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.
- I understand I may be charged \$25.00 if I do not show for an appointment or give less than a 24-hour notice to cancel or reschedule.
- I have received and read the "Advance Directives" and "HIPPA" Notice of Privacy Practices.
- I give permission for the staff to leave a message when calling to confirm appointments.

Signature X _____ Date: _____

Personal Health History

A. Name: _____ **Date:** _____ **DOB:** _____

B. History

Please list any family members with the conditions listed
(Family members may include: mother's mother, mother's father, father's mother, father's father, father, mother, siblings, children)

Condition:	Self		Family Member		List relation if yes
	Yes	No	Yes	No	
Allergies / Asthma					
Alcohol abuse					
Arthritis / Gout					
Blood disorders					
Cancer (type)					
Elevated cholesterol					
Diabetes					
Epilepsy					
Glaucoma					
Heart Disease					
High blood pressure					
Psychiatric problems					
Stroke					
Tuberculosis					
Other conditions not listed					

Name of spouse:
Your employer: _____ Occupation: _____
Who do we contact in case of emergency? Name: _____ Phone: () _____
Immediate family members living with you:

C. HOSPITALIZATIONS, OPERATIONS, AND INJURIES

List Cause or Type, Include psychiatric, but omit pregnancies	Year
1	
2	
3	
4	
5	

D. MEDICINES: List all currently used medicines. Include doses and non-prescription drugs

E. ALLERGIES: Please list all known Allergies, especially to medicines, and describe reaction

F. TESTS: Please give the year of the most recent test or immunization

G. HABITS	Yes	No	If Yes, then Describe
Smoking			
Coffee or Tea			
Alcohol/Drugs			
Exercise			
List any special interests or hobbies:			

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Consent for Photography (For Patient Identification Purposes)

Patient's Name: _____

Patient Chart Number: _____

(Office Use Only)

I hereby give my consent to have a facial photograph of myself or family member to be used for patient chart identification purposes only.

Signature of Patient

Date

*3104 Sunset Blvd., Suite 2B * Rocklin, CA 95677 Tel (916) 624-0300 Fax (916) 624-0631*

www.familymedicalpractice.info

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routing Physical Exams and Other Recommended Health Screenings

I understand that I am responsible for scheduling my annual routine physical exams. At that exam my doctor will explain to me which health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

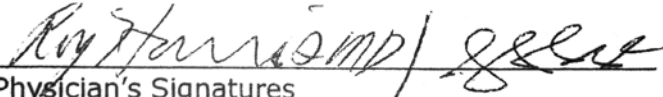
Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatments plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature

Date



Physician's Signatures

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PATIENT COPY

Roy Harris, M.D.
Julie Wei-Shatzel, D.O.

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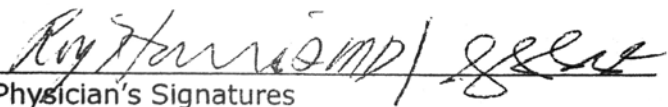
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To Our New Patients,

Welcome to ROCKLIN FAMILY PRACTICE AND SPORTS MEDICINE – We look forward to providing you and your family with quality health care. We are a Family Practice office established in Rocklin since 1988. We look forward to getting to know you, and the following information may help familiarize you with our office.

- 1) We offer same-day appointments but these are booked quickly, so we advise calling the office in the morning when we open at 8:30am if you would like to schedule a same-day visit.
- 2) As a convenience to our patients we offer on site blood draws (for most insurances.) You do not need to schedule an appointment for this procedure. Blood draws are performed on a walk-in basis from 8:30am –11:45am Monday through Friday. You will need to have an order from a medical provider in our office as we do not draw blood ordered by outside physicians, or you will need an appointment to go over the blood work drawn.
- 3) We offer on-site x-ray capability (for most insurances).
- 4) We offer on-site treadmill testing.
- 5) We offer on-site colon cancer screening with flexible sigmoidoscopy.
- 6) We offer bone density screening with on site DEXA scans (for most insurances).
- 7) We encourage yearly physical exams for both men and women and provide complete well woman visits including pap smears. Please ask to schedule a “Full Physical Exam” at our front desk.
- 8) We offer aesthetic services (Laser facials, Titan skin tightening, Acne treatment, Laser brown spot removal, Laser vein removal, Botox treatment, and Laser hair removal, Microdermabrasion and Glycolic peels) provided by our physicians and medical providers at our Laser office next door (not covered by insurance).
- 9) We require 72 hours turn-around time for medication refills.

If you have additional problems to discuss that were not scheduled for today’s visit, please feel free to schedule another appointment thus allowing us to provide adequate time for evaluation of each problem.

Thank you for your cooperation. We look forward to providing your health care.

Dr. Harris, Dr. Ooi, Dr. Wei-Shatzel, and Dr. Chima.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ROY HARRIS, M.D. INC. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

What is this Notice and Why it is important?

This notice is required by law to inform you of how our health information will be protected, how Roy Harris, M.D. may use or disclose your health information, and about your rights regarding your health information.

Understanding Your Health Information

Each time you visit our office a record of your visit is made. Typically, this record contains a description of your symptoms, examination, test results, diagnosis, and treatment plan. Your medical record serves as a basis for planning your care and treatment, a legal document of the care you receive, a means of communication among the health professionals who contribute to your care and a means by which you or a third-party payer (e.g. health insurance company) can verify that services you received were appropriately billed.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights related to your medical and billing records kept by Roy Harris, M.D., Inc.

Authorization to use your health information – Before we use or disclose your health information, other than as described below, we will obtain your written authorization, which you may revoke at anytime to stop future use or disclosure.

Access to your health information – You may request a copy of your medical or billing record. Your request must be submitted in writing. We charge for the costs of providing you access and for your copies.

Amend your health information – If you believe the information about you is incorrect or incomplete, you may request that we correct or add (up to 250 words) information. Your request must be in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and if we refuse, we will provide you with information about the denial and how you can disagree with the denial.

OUR RESPONSIBILITIES

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and businesses associates, and provide this notice about our privacy practices, and abide by the terms of this notice. We reserve the right to change our policies and procedures for protecting health information. A notice will be posted when a change is made.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when other wise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke your authorization at any time. We are to take back any disclosure we have already made with your permission.

Examples of Uses and Disclosures for Treatment, Payment and Healthcare Operations

We will use your health information to facilitate your medical treatment.

For example: Information obtained by members of your healthcare team will be recorded in our records and used to determine the course of your medical treatment. We may share medical information with other physicians, with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may disclose medical information to members of patient's families or others who can help them when they are sick or injured.

We will use your health information to collect payment for health care services that we provide. For example: A bill may be sent to you or your health insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. In some cases, information from your medical record is sent to your insurance company to explain the need for or provide additional information about your treatment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

We may use your health information to inform persons about your death.

For example: We may disclose health information to funeral directors, coroners, and medical examiners consistent with applicable law to carry out their duties.

Examples of Uses and Disclosures for Other Purposes

We may disclose medical information to contact and remind our patients about appointments. We may also call out our patient's name when we are ready to see them.

Your insurance may request information from your health record to authorize services or referrals or for a research project.

We may disclose your health information to the extent authorized by and necessary to comply with laws relating to worker's compensation or other similar programs established by law. We are also required by law to report cases of occupational injury or occupational illness to the employer.

We may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

We may disclose your health information to business associates. An example includes copy service companies we use when making copies of your health record.

If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

For More Information or to Report a Problem

If you have questions, would like additional information, disagree with a decision we have made about your rights or want to request an updated copy of this notice, you may contact our privacy manager at (916) 624-0300. This medical practice will investigate all complaints relating to the protection of health information in a timely fashion.

ADVANCE DIRECTIVES

Advance Directives Are Written Instructions Which Communicate Your Wishes About The Care And Treatment You Want If You Reach A Point Where You Can No Longer Make Your Own Health Care Decisions

All health care facilities that receive Medicare and Medi-Cal payments must provide patients with written information concerning 1) their right to accept or refuse treatment and 2) their right to prepare advance directives. The law does not require that you actually have or make an advance directive.

Under California law adult persons with decision-making capabilities have the right to accept or refuse medical treatment or life sustaining procedures. Artificial nutrition and hydration are among the medical procedures you have the right to accept or refuse.



REASON WHY YOU MAY WANT TO PREPARE AN ADVANCE DIRECTIVE

- To ensure you receive the care and services you desire.
- To ensure the refusal of treatment at a determined stage if you have previously stated your desires to do so.
- To designate the person you would like to make decisions on your behalf.
- To ensure that family and friends understand your wishes regarding health care. If you do not make your wishes clear, your family members and friends may not agree about what type of care and treatment you would want. It is possible that your desires will not be carried out, since a conflict may lead to a lengthy court delay.

Being Prepared With An Advance Directive, You Can Say WHAT Types Of Treatment You Want, and WHO You Want To Speak For You.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This is a legally binding document that allows the person you choose (the “agent”) to make health decisions for you if and when you are no longer able to make such decisions. You should select a person who knows you well, and whom you trust. Your agent may be a relative or a friend, but must not be your attending doctor. The Durable Power of Attorney for Health Care allows your agent to make any and all health care decisions for you once you are no longer able to decide. This includes routine medical decisions, as well as more complicated decisions. Your agent can even decide to withdraw or withhold life-sustaining procedures if you give your agent that authority.

To be valid, the document must be signed by you and witnessed by two qualified adult witnesses.

Those persons not eligible to be witnesses are your doctor, nurse, their employee or any other healthcare professional.

- You *DO NOT* need a lawyer to fill out a Durable Power of Attorney of Health Care.
- The Durable Power of Attorney for Health Care allows you, in writing, to declare your desire to receive or not receive life-sustaining treatment under certain conditions. You may list any instructions you want pertaining to health care.

THE NATURAL DEATH ACT

This is another type of advance directive most often called a “Declaration.” This document *DOES NOT* require you to appoint an agent to make health care decisions for you.

The Declaration is for terminally ill patients. While you still have decision making capabilities, you may sign a Declaration which tells your doctors that you don’t want any treatment that would prolong the dying process. The Declaration must be followed in these circumstances:

- If you fall into a permanent unconscious state or a terminal condition (certified by two doctors)
- At the time you cannot make your own health care decisions.

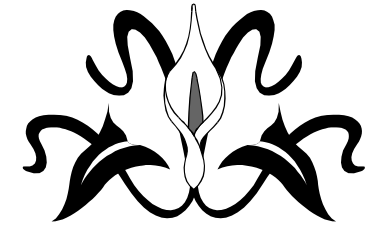
Those persons who are witnesses to the signing of the Declaration must meet the same requirements, as those needed for the Durable Power of Attorney for Health Care.

DO I NEED A SPECIAL FORM FOR THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE

YES. Use a *Durable Power of Attorney for Health Care* form, not a plain Durable Power of Attorney. You can ask your physician, nurse, or social worker about the form.

The California Medical Association has printed forms that meet the legal requirements. —
California Medical Association.
PO Box 7690
San Francisco, CA 94120-7690.
415-882-5175 or visit their website at:
www.cma.org

Many stationery stores carry the forms. There is a small charge for these forms from all sources.



OTHER DOCUMENTS

Other documents that help determine your health care desires IF and WHEN you are UNABLE to make such decisions for yourself:

“DO NOT RESUSCITATE.” This form allows your doctor to withhold “resuscitative measures,” should that be your desire. This should be signed by you, your doctor, and a surgeon. The law does not require witnesses and notarization. **NO ONE CAN MAKE YOU SIGN A “DO NOT RESUSCITATE” ORDER.**

“PREFERRED INTENSITY OF CARE.” This is a document of your preferences for care under special circumstances. A discussion with your physician and/or legal representative occurs prior to creating this document.

“LIVING WILL.” This lists your desires to receive or not receive life-sustaining medical treatment under certain circumstances. A living will is NOT a legally binding agreement, although it is often accepted as an accurate statement of one’s wishes.