

**PATIENT NAME:**

( ) Male  
( ) Female

\_\_\_\_\_ **First** \_\_\_\_\_ **Middle** \_\_\_\_\_ **Last**  
**Date of Birth:** \_\_\_\_\_  
**Social Security** \_\_\_\_\_

**If patient is a minor please name parent or guardian.**

Name of person legally responsible: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
\_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip**

**Home Address:** \_\_\_\_\_  
\_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip**

**Home Phone Number:** ( ) \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_

**Cell Phone:** ( ) \_\_\_\_\_

**Employed by:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Business Address:** \_\_\_\_\_  
\_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip**

**Who do we contact in case of an emergency?**

**Name :** \_\_\_\_\_ **Phone Number:** ( ) \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Immediate family members living with you: \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_

\_\_\_\_\_ **Street** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone**

**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: \_\_\_\_\_

I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

**PATIENT OR AUTHORIZED PERSON SIGNATURE:**

- I authorized 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** \_\_\_\_\_ **Date** \_\_\_\_\_

# Personal Health History

**A. Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

## B. Family History

Please list any family members with the following conditions:

(family members may include: mother's mother, mother's father, father's mother, father's father, father, mother, siblings, children)

Condition:	Yes	No	If Yes, then list family relationship :
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			List condition & family relationship:

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	
6	
7	
8	

**D. SERIOUS ILLNESS:** List current or past illnesses not mentioned above

1
2
3
4
5

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


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


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


**H. HABITS**

	Yes	No	If Yes, then Describe
Smoking			
Coffee or Tea			
Alcohol/Drugs			
Exercise			

List any special interests or hobbies: \_\_\_\_\_

## 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.

To Our New Patients,

Welcome to 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 (for most insurances).
- 5) We offer on-site colon cancer screening with flexible sigmoidoscopy (for most insurances).
- 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 and Associates

# 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. The document must also be 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](http://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 allow 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.

**AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: \_\_\_\_\_  
Address of Provider: \_\_\_\_\_  
\_\_\_\_\_

Fax Number: \_\_\_\_\_

**Recipient and Address for Delivery of Records:**

**Purpose:** I understand that the specific purpose of this Authorization is \_\_\_\_\_  
\_\_\_\_\_

**Information to be disclosed:** This authorization permits the above named health care provider to disclose the following medical records:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.
- All of my health information described above except for the following:
- Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)

**Term:** This Authorization will remain in effect for one (1) year from the date this authorization is signed



## PHYSICIAN-PATIENT ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

**Article 4: General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

**Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:**

**Effective as of the date of first medical services**

\_\_\_\_\_  
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

By: \_\_\_\_\_  
Physician's or Authorized Representative's Signature (Date)  
\_\_\_\_\_  
Print or Stamp Name of Physician, Medical Group, or Association Name

By: \_\_\_\_\_  
Patient's or Patient Representative's Signature (Date)

By: \_\_\_\_\_  
Print Patient's Name  
\_\_\_\_\_  
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.