MPG
THE MEDICAL PARTNERS GROUP
568 E. Herndon Avenue, Suite 102 · Fresno, CA 93720
559-221-7500 · Fax 559-248-2472

New Patient Packet

Complete every applicable field. Nothing entered in this PDF is transmitted automatically.

Welcome to The Medical Partners Group. Our team supports diverse health needs across ages and genders through preventive care, same-day and sick visits, and care for chronic conditions.

Preparing for your first appointment

- Review and complete the entire packet. Incomplete forms may delay your appointment.
- Arrive 20 minutes early and bring photo ID, insurance cards, and all current medications in their original containers.
- Transferring records from a previous provider is optional for the initial appointment. The practice can provide a release form to fax to that provider.
- Insurance co-payments are due when services are performed.

PATIENT REGISTRATION INFORMATION

Last name _____ **First name** _____ **MI** _____ **Date of birth** _____

Sex

○ Male ○ Female

Social Security number _____ **Email** _____

Street address _____ **Apartment** _____

City _____ **State** _____ **ZIP code** _____

Primary phone _____ **Secondary phone** _____

Primary phone type

○ Home ○ Cell

Secondary phone type

○ Home ○ Cell

Relationship status

○ Married ○ Single ○ Divorced

○ Widowed ○ Registered domestic partner

Number of children _____

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Race / ethnicity

- [ ] Black/African American
- [ ] White/Caucasian
- [ ] Native Hawaiian/Pacific Islander
- [ ] Asian
- [ ] Hispanic
- [ ] American Indian/Alaska Native
- [ ] Prefer not to specify

Preferred language

- ○ English
- ○ Spanish
- ○ Hmong
- ○ Lao
- ○ Punjabi
- ○ Hearing impaired/Sign
- ○ Vietnamese
- ○ Other

Other preferred language

How did you hear about our practice?

- ○ Mailer
- ○ Friend/Family
- ○ Online
- ○ Referral
- ○ Other

Other referral source

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Contacts, pharmacy and insurance

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EMERGENCY CONTACT 1

Name

Relationship to patient

Home phone

Cell phone

Work phone

EMERGENCY CONTACT 2

Name

Relationship to patient

Home phone

Cell phone

Work phone

Preferred pharmacy

Phone

Guarantor information

- ○ Same as patient
- ○ Different from patient

PRIMARY INSURANCE

Insurance

Co-pay

Subscriber's name

Subscriber's SSN

Subscriber DOB

Group number

Policy number

Patient's relationship to subscriber

- ○ Self
- ○ Spouse
- ○ Child
- ○ Other

Other relationship

SECONDARY INSURANCE, IF APPLICABLE

Insurance

Co-pay

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Subscriber's name

Subscriber's SSN

Subscriber DOB

Group number

Policy number

Patient's relationship to subscriber

- ○ Self
- ○ Spouse
- ○ Child
- ○ Other

Other relationship

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Current problems and medical history

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Current health problems — answer Yes or No for each

Stroke	○ Yes	○ No
Allergies	○ Yes	○ No
Kidney disease	○ Yes	○ No
Heart disease	○ Yes	○ No
Tuberculosis	○ Yes	○ No
Pneumonia	○ Yes	○ No
Bleeding/clotting problems	○ Yes	○ No
High blood pressure	○ Yes	○ No
Heart attack	○ Yes	○ No
Jaundice/hepatitis	○ Yes	○ No
Speech/hearing problems	○ Yes	○ No
Diabetes	○ Yes	○ No
Blood transfusions	○ Yes	○ No
Cancer	○ Yes	○ No
Back problems	○ Yes	○ No
Arthritis	○ Yes	○ No
Stomach/ulcer	○ Yes	○ No
Emphysema	○ Yes	○ No
Rheumatic fever	○ Yes	○ No
Other	○ Yes	○ No

Blood transfusion date

Other current health problem

Family history

- ☐ Stroke
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Other

Other family history

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Past surgical history

- [ ] Ear/Nose/Throat
- [ ] Hysterectomy
- [ ] Appendectomy
- [ ] Joints (Hip/Knee)
- [ ] Hernia
- [ ] Eye
- [ ] Hemorrhoid
- [ ] Breast
- [ ] Back/Neck
- [ ] Gallbladder
- [ ] Heart/Vascular
- [ ] Other/Hospitalizations

Other surgeries or hospitalizations

Unusual childhood illnesses

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Medical and behavioral health history

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History of medical problems — check all that apply

- ☐ High blood pressure
- ☐ Stroke/TIA
- ☐ Heart problems
- ☐ Sugar diabetes
- ☐ Thyroid (low/high)
- ☐ Chronic pain
- ☐ Headaches
- ☐ Anxiety
- ☐ Blood clot problems
- ☐ Asthma
- ☐ Nerve problems
- ☐ Cancer
- ☐ Stomach ulcers
- ☐ Vein problems
- ☐ Liver problems
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Eye problems
- ☐ Gout
- ☐ Arthritis
- ☐ Bladder problems
- ☐ Prostate problems
- ☐ Skin problems
- ☐ Recurrent infections
- ☐ Other

Other medical history

Are you, or have you ever been, under the care of a psychiatrist/psychologist?

- ○ Yes
- ○ No

If yes, explain and name the provider

Check any that apply

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Dysthymia
- ☐ Anxiety
- ☐ Suicidal

Sex assigned at birth

- ○ Male
- ○ Female

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Current medications and allergies

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List all current medications, including strength, dosage, timing and reason. Attach another list if necessary.

Medication	Dosage	When taken	Reason

Allergies and reaction symptoms

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Social history

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Do you drink alcohol?

- ○ Yes
- ○ No

Beer bottles/day

Wine glasses/day

Liquor drinks/day

Do you smoke?

- ○ Yes
- ○ No

Packs per day

Number of years

Do you use other nicotine products?

- ○ Yes
- ○ No

If yes, explain

Recreational drugs, if any

Do you exercise regularly?

- ○ Yes
- ○ No

Times per week

Type of exercise

Diet

- ☐ Regular
- ☐ Diabetic
- ☐ Low fat
- ☐ Low salt
- ☐ Other

Other diet details

Caffeine use

- ○ Yes
- ○ No

Cups per day

Hobbies

Do you use a seatbelt?

- ○ Yes
- ○ No

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Do you wear glasses or contacts?

- [ ] Glasses
- [ ] Contacts
- [ ] Neither

Do you wear hearing aids?

- ○ Yes
- ○ No

Do you have a legal guardian or Healthcare Power of Attorney?

- ○ Yes
- ○ No

If yes, who is your guardian or POA?

Do you have a Living Will or Advance Directive? Provide the office a copy if yes.

- ○ Yes
- ○ No

Do you have a DNR order? Provide the office a copy if yes.

- ○ Yes
- ○ No

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Other providers

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Provide a complete list of other providers you see so The Medical Partners Group can coordinate your care.

Specialty	Provider name	Contact information

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Patient financial responsibility

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1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

Our practice participates in most insurance plans. However, since each plan has different requirements, coverage limitations and exclusions, it is the patient's responsibility to understand and meet the requirements of the individual plan.

- Payment is due when services are rendered. The practice accepts cash, check, debit and/or credit card.
- I am financially responsible for my deductible, coinsurance and non-covered services.
- Co-payments are due at time of service.
- If my health plan determines a service is not payable, I am responsible for the complete charge.
- If uninsured, I agree to pay at time of service or discuss self-pay payment-plan options with TMPG.
- A $25 fee applies to a check returned for insufficient funds.

Health plans may not cover all costs. Patient-responsible charges are due when services are rendered.

COPAY: The patient portion not covered by insurance, collected at each visit; preventive annual physicals may be exempt.

DEDUCTIBLE: The annual amount paid before the health plan pays covered services. With a high deductible and no significant medical expenses, the entire visit may be out of pocket because office charges are often below the deductible.

COINSURANCE: The percentage of maximum allowable charges paid after the deductible; it may vary by service.

OUT-OF-POCKET MAXIMUM: The maximum patient responsibility per calendar year; after it is reached, covered expenses are paid at 100% with no further copay, deductible or coinsurance.

MAXIMUM ALLOWABLE CHARGE / CONTRACTUAL DISCOUNT: The negotiated covered-service price accepted by a participating provider. The difference between cash and negotiated prices is the contractual discount.

NON-COVERED SERVICES: Services excluded by the patient's health-plan contract. Insurers may specify exclusions, and coverage varies significantly by plan.

If the account balance exceeds $50, the outstanding balance must be paid by cash or credit card before further services are provided.

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Authorizations and office policies

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2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize and direct payment of my medical benefits to The Medical Partners Group for services furnished by its providers, including Dr. Rohan Gupta. I am responsible for knowing the nature and scope of coverage. A TMPG provider may not participate in my insurance company or plan, and some or all services may not be covered; I remain responsible for payment.

3. AUTHORIZATION TO RELEASE RECORDS

I authorize The Medical Partners Group and its providers to release to my insurer, governmental agencies, or another entity financially responsible for my care all information, including diagnoses and records of treatment or examination, needed to substantiate payment, precertification, authorization, or referral to other providers.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits for services furnished by The Medical Partners Group and authorize release to Medicare and its agents of information needed to determine benefits.

5. NO-SHOW AND CANCELLATION POLICY

Provide at least 24 hours' notice to cancel. Late cancellations and no-shows may incur a $35 fee payable before the next visit. The practice may discharge a patient for multiple missed appointments.

6. MEDICAL RECORDS REQUEST

Copies are provided subject to charges allowed under Health & Safety Code section 123100 and annual statutory adjustment. The source policy states a per-page fee not to exceed .25 cents per page.

7. FORMS COMPLETION POLICY

Paperwork for schools, employers, FMLA, long-term care, life insurance, DMV and disability claims is not routine medical care and cannot be billed to insurance. All forms require a provider signature, and the practice is responsible for accuracy. Incomplete or inaccurate information may have far-reaching consequences, so careful review and considerable time are required. The processing fee is $25 per form. The form will be faxed or returned within five business days after payment.

8. PRESCRIPTION REFILLS

New patients should obtain medication from their previous physician until establishing care. Established-patient requests are processed within two business days, although exceptions may or may not be granted; request one week before running out or two weeks for mail order. Use the portal or pharmacy. Diuretics, blood-pressure and cholesterol medicines, anti-seizure medicines, sleep aids, painkillers and stimulants may require recent blood work and/or visits. Patients not seen in 12 months need an appointment for renewal.

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Acknowledgment and HIPAA

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FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

By signing below, I acknowledge that: (i) I received the TMPG Patient Financial Responsibility Form; (ii) I read, understand and agree to its provisions; (iii) I agree to pay charges due for the patient's care, including copayments and deductibles; (iv) third-party benefits will be credited to the account; (v) I am ultimately responsible for the balance regardless of insurance; (vi) I am responsible for collection costs if I do not pay in a timely manner; and (vii) late payment charges may apply. A photocopy is as valid as the original, and the agreement is in full force after signing.

Print patient/authorized representative/responsible party

Relationship to patient

Signature

Date

HIPAA REGULATIONS

The Health Insurance Portability and Accountability Act (HIPAA), passed in 1996, primarily enables workers to carry healthcare insurance between jobs, prohibits discrimination against beneficiaries with pre-existing conditions, and guarantees coverage renewability for multi-employer health plans.

The HIPAA Privacy Rule establishes national standards protecting medical records and other individually identifiable health information. It applies to health plans, healthcare clearinghouses, and providers conducting certain transactions electronically. The Rule requires safeguards, limits uses and disclosures without authorization, and gives individuals rights to examine and obtain records, direct electronic transmission to a third party, and request corrections.