THE MEDICAL PARTNERS GROUP

KEVIN ORITA, MD
INTERNAL MEDICINE
568 E. Herndon Ave Suite #102
Fresno, CA. 93720
Ph: (559) 221-7500 Fx: (559) 248-2472

NEW PATIENT PACKET

Welcome to The Medical Partners Group, Dr. Kevin Orita's office. We are pleased that you have chosen us to be your primary care provider. Dr. Orita is committed to serving the diverse health needs of patients of all ages and genders. We are here for same-day appointments, preventative care, sick visits, and chronic conditions. Dr. Orita strives to provide the best care for all his patients. Our team is committed to providing high quality care and treatment you deserve!

Enclosed is our New Patient Packet. We ask that you **thoroughly review and complete the enclosed paperwork. It is very important that all the enclosed forms are completed in full.** Please bring the completed paperwork to our office the day of your appointment. As a reminder, returning incomplete forms will result in a delay of your scheduled appointment time.

If you are transferring your care from another provider, you may contact that provider and request that your records be transferred to us, however, this is not a requirement for your initial appointment. If you do choose to do this, our staff will provide you with a medical record release form upon your request. Once filled out, our staff will fax it to your previous provider.

As a new patient, we ask that you arrive 20 minutes prior to your scheduled appointment time. **You must bring at least one form of identification (driver's license, State ID), your insurance card(s), and all current medications in the original containers.** All insurance co-pays are due and must be paid for all services performed at the time of the visit.

Thank you for choosing The Medical Partners Group, Dr. Kevin Orita's office.
We look forward to serving your healthcare needs.

MPG
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NEW PATIENT REGISTRATION INFORMATION –

Last Name: _____ First Name: _____ MI: _____

DOB: _____ ☐ Male ☐ Female SSN: _____

Street Address: _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Email: _____

Primary Ph#: _____ ☐ Hm ☐ Cell ☐ Second Ph#: _____ ☐ Hm ☐ Cell

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner ☐ Widowed # of children: _____

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/ Please Specify: _____

How Did You Hear About our Practice? ☐ Mailer ☐ Friend/Family ☐ Online ☐ Referral ☐ Other

IN CASE OF AN EMERGENCY –

Emergency Contact #1: _____ Relationship to Pt: _____
Hm Ph: _____ Cell Ph: _____ Wk Ph: _____

Emergency Contact #2: _____ Relationship to Pt: _____
Hm Ph: _____ Cell Ph: _____ Wk Ph: _____

Preferred Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION – Guarantor Information: ☐ *Check here if same as patient.*

Please give your insurance card to the receptionist

PRIMARY INSURANCE –

Insurance: _____ Co-pay: $_____
Subscriber's Name: _____ Subscriber's SS #: _____
Date of Birth: _____ Group#: _____ Policy#: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY INSURANCE *(If Applicable)* –

Insurance: _____ Co-pay: $_____

Subscriber's Name: _____ Subscriber's SS #: _____

Date of Birth: _____ Group#: _____ Policy#: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CURRENT PROBLEMS –

Health Problems *(Please check all that apply)* –

Yes	No		Yes	No	
☐	☐	Stroke	☐	☐	Speech/Hearing Problems
☐	☐	Allergies	☐	☐	Diabetes
☐	☐	Kidney Disease	☐	☐	Blood Transfusions Date: _____
☐	☐	Heart Disease	☐	☐	Cancer
☐	☐	Tuberculosis	☐	☐	Back Problems
☐	☐	Pneumonia	☐	☐	Arthritis
☐	☐	Bleeding/Clotting Problems	☐	☐	Stomach/Ulcer
☐	☐	High Blood Pressure	☐	☐	Emphysema
☐	☐	Heart Attack	☐	☐	Rheumatic Fever
☐	☐	Jaundice/Hepatitis	☐		Other: _____

Family History *(Please check all that apply)* –

☐ Stroke	☐ Cancer	☐ Other: _____
☐ Heart Disease	☐ Diabetes	
☐ Kidney Disease	☐ High Blood Pressure	

PAST MEDICAL HISTORY –

Past Surgical History *(Please check all that apply)* –

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

Please list all unusual childhood illnesses you have had? _____

_____

_____

Do you have a history of the following medical problems? *(please 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 _____

_____

Are you, or have you ever been, under the care of a psychiatrist/psychologist? ☐ Yes ☐ No
If yes, please explain and name of provider: _____

Please check any or all that apply:
☐ Depression ☐ Bipolar disorder ☐ Schizophrenia ☐ Dysthymia ☐ Anxiety ☐ Suicidal

Sex Assigned at Birth: ☐ Male ☐ Female

Please list all of your current medications, including the strength and dosage. If you have a list, we may ask for a copy. You may use the back of this paper, if necessary:

Medication	**Dosage** (mgs, units, drops)	**When is it taken** (daily, am, pm)	**Reason you take it** (blood pressure, diabetes, etc.)

Are you allergic to anything? If so, please list, and describe your reactive symptoms: _____

_____

_____

SOCIAL HISTORY –

Do you drink alcohol? ☐ Yes ☐ No If yes, what do you drink and what is your average in a day?
☐ Beer _____ bottles ☐ Wine _____ glasses ☐ Liquor _____ drinks

Do you smoke? ☐ Yes ☐ No If yes, you smoke an average of _____ packs per day and for _____ years?

Do you use other nicotine products? ☐ Yes ☐ No If yes, please explain: _____

Do you use any recreational drugs? Please list them: _____

Do you exercise on a regular basis? ☐ Yes ☐ No If yes, how many times per week? _____
Type of exercise? _____

Diet (*circle all that apply*): ☐ Regular ☐ Diabetic ☐ Low Fat ☐ Low Salt ☐ Other_____

Caffeine Use: ☐ Yes ☐ No If yes, how many cups per day? _____

Hobbies: _____

Do you use a seatbelt? ☐ Yes ☐ No Do you wear glasses or contacts? (*circle all that apply*): ☐ 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 POA? _____

Do you have a Living Will or an Advanced Directive? ☐ Yes ☐ No If yes, please provide our office with a copy.

Do you have a DNR (Do Not Resuscitate) order? ☐ Yes ☐ No If yes, please provide our office with a copy.

In order to provide you with the best possible care, we ask that you give us a complete list of other providers you see.

Doctor Specialty	Doctor Name	Contact Information
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PATIENT FINANCIAL RESPONSIBILITY FORM

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 responsibility of the patient to understand and meet the requirements of their individual plan.

- Payment is due at the time services are rendered. The Practice accepts cash, check, or debit and/or credit card payment.
- I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered services.
- Co-payments are due at time of service.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am un-insured, I agree to pay for the medical services rendered to me at time of service or have the option to speak with TMPG financial department to discuss options of a "self-pay" payment plan.
- You will be charged a $25.00 fee for any payment by check which is returned for non-sufficient funds.

Please understand that health insurance plans MAY NOT COVER ALL OF THE COST of our services. The charges for which you, the patient, are responsible for are detailed below. The payment for these charges is due at the time services are rendered.

COPAY - A portion of the charge that is not covered by insurance and due from the patient. This is collected at each office visit (preventive visit 'annual physical' may be exempt).

DEDUCTIBLE - The amount of money that you must pay each year BEFORE the health insurance plan starts to pay for any covered services. If you have a high deductible and you have not had any significant medical expenses, it is likely that you will need to pay for the entire office visit out of pocket (since our charges are much lower than most deductibles).

COINSURANCE - Your health insurance plan may require that after you meet your deductible you continue to pay a portion of the medical expenses - coinsurance is the percentage of maximum allowable charges that you will be required to pay. Coinsurance may vary according to the type of service(s) provided.

OUT-OF-POCKET MAXIMUM - The maximum amount that you are responsible for per calendar year. Once you pay this amount, the insurance plan will pay for all covered medical expenses at 100% (*i.e. there are no further copays, deductibles, or coinsurance payments*).

MAXIMUM ALLOWABLE CHARGES, CONTRACTUAL DISCOUNT - As a condition of participation in your insurance network, we have agreed to accept lower payment for covered services than our 'cash' prices. Even if you are responsible for payment for services because of deductible, we cannot charge you more than the maximum allowable charge specified by your insurance. The difference between our 'cash' prices and the insurance negotiated prices is the 'contractual discount'.

NON-COVERED SERVICES - Your contract with the insurance company ('Health Plan') will likely specify that some services are not covered. Insurance companies are free to specify which services can be excluded from coverage. Health plans vary significantly in what they cover.

If your account has a balance exceeding $50 we require that you pay the outstanding balance by cash or a credit card before we provide any further services to you.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to The Medical Partners Group on my behalf for any services furnished to me by their provider, Dr. Kevin Orita. You are responsible for knowing the nature and scope of your health insurance coverage. It is possible that Dr. Kevin Orita is not a participating provider with your particular insurance company and/or plan. Further, it is also possible that some or all the services the Practice provides at a given time may not be covered by your insurance company and/or plan. You will nevertheless be responsible for the payment of such items and services.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Dr. Kevin Orita to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by Dr. Kevin Orita. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

5. NO SHOW & CANCELLATION POLICY

If you need to cancel your appointment with us, we ask that you give at least 24 hours' notice. For appointments that are cancelled within less than 24 hours *or* for "no show" appointments, you may be charged a $35 fee. This will be payable prior to your next visit. We also reserve the right to discharge a patient for multiple missed appointments.

5. MEDICAL RECORDS REQUEST

Upon request, we will provide you with copies of medical records, subject to the following charges as provided under the Health & Safety Code section 123100 (charges are subject to annual adjustment based on statute). Per page fee, not to exceed .25 cents per page.

5. FORMS COMPLETION POLICY

Completing paperwork for schools, employers, the Family Medical Leave Act (FMLA) claims, long-term care, life insurance, the Department of Motor Vehicles, and disability claims goes beyond your routine medical care. Therefore, **it cannot be billed to your insurance company**. Since all forms require your physician's signature, we are personally responsible for the accuracy of the information provided. Incomplete or inaccurate information may have far-reaching consequences for your case. Filling out forms thus requires careful consideration and a considerable amount of our time. Therefore, it is our office policy to charge for the completion of any form as follows: Processing fee of $25 per form. We will

complete the form and fax it to the designated recipient (*or return it to you if you prefer*) within 5 business days of receipt of payment.

5. PRESCRIPTION REFILLS

If you are a new patient, please contact your previous physician to obtain adequate supply of medication(s) until you can establish care with us. For established patients, please keep the following in mind when requesting a refill - OUR OFFICE POLICY IS TO PROCESS MEDICATION REFILLS WITHIN TWO (2) BUSINESS DAYS. Exceptions to this policy may or may not be granted. To have a safety margin, please request your refill at least ONE (1) WEEK BEFORE you run out of the medication(s). For mail-order, please let us know at least TWO (2) WEEKS BEFORE you run out. Prescription refill requests are most efficiently handled through your patient portal which is available on our website on the "Care Portal" tab. Alternatively, you may contact your pharmacy so that they request a refill on your behalf.

Many medications (especially diuretics [water pills], blood pressure and cholesterol-lowering medications, anti-seizure medications, sleep aids, painkillers, stimulants) require periodic blood work and/or office visit to ensure safe and effective use. If we do not have recent results and/or an office visit, we will not be able to process your refill. If you have not been seen in this practice within the past twelve months, it is our policy that you must have an appointment to renew your medication(s). If you are a new patient, please contact your previous physician to obtain adequate supply of medication(s) until you can establish care with us.

ACKNOWLEDGEMENT

By signing below, the undersigned acknowledges that: (i) I have been provided a copy of The Medical Partners Group (TMPG) PATIENT FINANCIAL RESPONSIBILITY FORM; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to TMPG for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed; and (vii) failure to pay when due may subject me to late payment charges.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Signature of Patient, or Authorized Representative or Responsible Party Date

_____ _____

Print Patient Name, or Authorized Representative or Responsible Party Relationship to Patient

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HIPPA REGULATIONS

The Health Insurance Portability and Accountability Act (HIPAA) is an Act passed in 1996 that primarily had the objectives of enabling workers to carry forward healthcare insurance between jobs, prohibiting discrimination against beneficiaries with pre-existing health conditions, and guaranteeing coverage renewability multi-employer health insurance plans.

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as “protected health information”) and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of protected health information and sets limits and conditions on the uses and disclosures that may be made of such information without an individual’s authorization. The Rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third party an electronic copy of their protected health information in an electronic health record, and to request corrections.