Dignity Health Medical Group.
Inland Empire
A Service of Dignity Health Medical Foundation

PATIENT INFORMATION

Do you need an Interpreter ?			What is your primary language?		
Last Name	First Name	M.I.	Sex (M/F)	Date of Birth	Social Security Number
Patient's Address		City		State	Zip Code
Patient's Home Telephone	Work Phone	Message Phone		Marital Status (S,M,D, or W)	
Patient's Employer	Employer's Street Address		City, State, Zip Code		Telephone

GUARANTOR INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR OR FULL-TIME STUDENT)

Father's Name (Last, First, MI)	Father's Address (If different from than Patient's)	
Father's Employer	Employer's Street Address	City, State, Zip Code
Father's Social Security No.	Date of Birth	Business Phone
Mother's Name (Last, First, MI)	Mother's Address (If different from than Patient's)	
Mother's Employer	Employer's Street Address	City, State, Zip Code
Mother's Social Security No.	Date of Birth	Business Phone

SPOUSE OR EMERGENCY INFORMATION

Last Name	First Name	Relationship	Telephone

INSURANCE INFORMATION

Primary Insurance Co.	Policy Number	Group Number	Plan Code
Subscriber Name	Date of Birth	SS#	Employer
Secondary Insurance Co.	Policy Number	Group Number	Plan Code
Subscriber Name	Date of Birth	SS#	Employer

DOES THE PATIENT HAVE ANY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE BELOW:

Insurance Co.	Subscriber	Policy Number

NEAREST RELATIVE (NOT LIVING WITH YOU)

Relative's Name	Street Address	Phone Number

How did you hear about our clinic
Please check boxes and indicate which

☐ **Newspaper** ☐ **Radio** ☐ **Television**
☐ **Family, Friend** ☐ **Postcard Mailing** ☐ **Insurance Co.**
☐ **Website** ☐ **Physician Referral** ☐ **Other (please specify)** ____________________

My signature below authorizes the above named insurance company(s) to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of medical information to said insurance company. Additionally, my signature provides willing consent to the procedures which may be performed, including emergency treatment or services, and which may include but is not limited to, laboratory procedure, x-ray exams, medical or surgical treatment of procedures, anesthesia, or services rendered to the patient under the general and special instructions of the patient's physician or his designate.

______________________________ ______________________________
Signature If Not Patient, Relationship

____
Date

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CONSENT TO TREATMENT

Name of Patient: ______________________________ **Date:** ____________________

Birth Date: ________________________

1. <u>Consent to Treatment:</u> The undersigned consents to health care encompassing routine diagnostic procedures and other health services rendered to the patient by Dignity Health Medical Group-Inland Empire, and its duly authorized agents and personnel.

2. <u>No Guarantees:</u> It is understood that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the results of treatments, examinations or other health services rendered by Dignity Health Medical Group-Inland Empire.

3. <u>Release of Information:</u> The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement. Dignity Health Medical Group-Inland Empire may disclose portions of the patient's records, including his/her medical records, to any person or entity which is or may be liable, for all or any portion of Inland HealthCare Group's reimbursement for charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. <u>Assignment of benefits:</u> The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Inland HealthCare of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by the patient's health plan, at a rate not to exceed Dignity Health Medical Group-Inland Empire's regular charges. It is agreed that payment to Dignity Health Medical Group-Inland Empire, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood that he/she is financially responsible for charges not covered by this assignment pursuant to Paragraph 5 below.

5. <u>Financial Agreement:</u> If the patient is not a member of an HMO at the time services are rendered, the undersigned agrees, whether he/she signs as agent or as patient that he/she hereby individually obligates himself/herself to pay the account to Dignity Health Medical Group-Inland Empire ;in accordance with the regular rates and terms of Dignity Health Medical Group-Inland Empire in accordance with the regular rates and terms of Dignity Health Medical Group-Inland Empire. Should the account be referred to an attorney or collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

6. <u>Certification:</u> The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or duly authorized by the patient as the patient's general agent to execute this Agreement and to accept its terms.

______________________________ Signature ______________________________
Date and Time Of Signing — Patient/Parent/Guardian/Conservator/Other

______________________________ ______________________________
Witness — If signed by other than patient, indicate relationship

Financial responsibility Agreement by Person Other Than the Patient or the Patient's Legal Representatives, I agree to accept financial responsibility for services rendered to patient and to accept the terms of the Financial Agreement and Assignment of Insurance Benefits Provisions above

______________________________ Signature ______________________________
Date and Time of Signing — Financially Responsible Party

Driver's License Number/Identification Card Number/Social Security Number ______________________

____
Witness

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CONSENT TO IMMUNZATION(S)

Patient Name: ______________________________ Date of Birth: ____________________

I hereby authorize Dignity Health Medical Group/IE to administer to my child/myself immunizations as recommended by the American Academy of Pediatrics, the American Academy of Family Practice, and Advisory Committee on Immunization Practices.

I understand this immunization schedule will provide protection from the following

Diseases:

Diphtheria	Chicken Pox	Haemophilus Influenza B
Tetanus	Measles	Pneumococcal Infection Vaccine
Pertussis	Mumps	HPV Infection
Hepatitis A	Rubella	Rotavirus
Hepatitis B	Polio	Meningococcal Infection

I understand I will have to return at designated intervals to complete each vaccination series. I further understand that the time intervals may change depending on the health status of my child/myself.

I understand I will be given education material provided by the Center for Disease Control For me to read prior to each immunization administration. This information will explain the Questions regarding the proposed immunization administration and have questions Answered to my satisfaction.

If any unforeseen condition arises in the course of the above-identified procedure calling on His/her judgment for procedures in addition to or different from those now contemplated. I Further authorize Dignity Health Medical Group/IE to do whatever seems advisable.

I further understand that I may refuse immunization of myself or my child at any time During the course of the immunization schedule. This refusal will in no way impede receipt Of medical care from Dignity Health Medical Group/IE.

________________ ______________________________________

Date Signature (Parent/Guardian if under 18 years of age)

________________ ______________________________________

Time Witness

CONSENT TO RELEASE VERBAL OR WRITTEN INFORMATION

The State of California mandates that medical information may be shared only with the patient, or the patient's legal representative In accordance with this law, every employee of Dignity Health Medical Group is required to sign a Confidentiality Statement on an annual basis, indicating they will keep the medical information of every patient in the strictest confidence.

Adhering to the Confidentiality Policy is difficult when family members (spouse, children, siblings) inquire about a patient's medical care. The staff and/or physicians cannot release medical information without permission from the patient or the patient's legal representative.

If you wish to **give permission** for staff and/or physicians to **verbally release general medical information to family members,** list the name(s), and relationship of those individuals in the space provided below. Please attach a copy of the driver license or any picture ID to confirm the identity of the authorized individuals acknowledged below. "General medical information" excludes the discussion of Psychiatric Services, Drug and Alcohol Counseling, Sexually Transmitted Diseases, HIV Testing, Pregnancy or Termination of Pregnancy.

If you **do not wish to give permission** for general medical information to be released verbally to family members, check here: ____ and sign below.

____________________	__________	____________________
Name	DOB	Relationship
____________________	__________	____________________
Name	DOB	Relationship
____________________	__________	____________________
Name	DOB	Relationship

I authorize that the above individual(s) may have access to information regarding any general medical condition. I will notify Dignity Health Medical Group in writing if I wish to add or delete individuals who may have access to my medical information.

____________________	____________________
Name of Patient	Date
____________________	____________________
Patient's/Parent/Signature	Witness