GOOD LIFE MEDICAL GROUP PATIENT REGISTRATION FORM

Please print clearly

Date____/____/____

Patient Name_____
Other name used _____
SSN_____ Drv Lic # _____ State _____
Home Address _____
City_____ State_____ Zip _____
Employer Name _____
Employer Address _____
City_____ State_____ Zip _____
Language preferred: ❒ Spanish or ❒ English
Email Address: _____

Birth date_____ Age _____
Sex: Male Female
Marital Status: S M D W
Occupation_____
Mother's maiden name_____
Home Tel:_____
Work Tel:_____
Cell #: _____
Pharmacy # _____

EMERGENCY CONTACTS (family member / friend. Someone we may contact besides the parent with different phone number.

Name _____
Home Address _____
City_____ State_____ Zip _____

Relationship _____
Home Tel: _____
Work Tel: _____

PATIENT INSURANCE INFORMATION: do you have health insurance? ( ) Yes ( ) No **Please fill out ALL insurance info.**

Primary insurance:

Insurance Co._____
Address _____
City_____ State_____ Zip _____
Insurance Phone # _____
Subscriber _____
Subscriber DOB _____
Subscriber SSN _____
Policy # _____
Group # _____
Effective Date _____
Medical Group _____

Secondary Insurance

Insurance Co._____
Address _____
City_____ State_____ Zip _____
Insurance phone #_____
Subscriber_____
Subscriber DOB _____
subscriber SSN _____
Policy # _____
Group # _____
Effective Date _____
PCP on Insurance Card: _____

CONSENT TO TREATMENT AND FINANCIAL AGREEMENT

I / We do here by consent to an authorize performance of all treatment, surgery and medical service by the staff of GOOD LIFE MEDICAL GROUP which they deem advisable.

I hereby certify that to the best of my knowledge, all statement contained hereon are true. I understand that I am directly responsible for all charges incurred by medical services for myself and my dependents regardless of insurance coverage.

I furthermore agree to pay legal interest, collection expense and attorney's fee should it become necessary to assign any amount I may owe for collection.
I also hereby authorize the GOOD LIFE MEDICAL GROUP to release information requested by my insurance company for services rendered. I authorize all payments for these services to be paid directly to GOOD LIFE MEDICAL GROUP.

I fully understand that this agreement and consent will continue until canceled by me in writing.

Parent / Guarantor Signature:	Guarantor Relationship:	Date:

Good Life Medical Group
New Patient Questionnaire

Name:_____
Date of Birth:_____ Age:_____ Gender: Female/Male
Previous Provider/Physician:_____
Address:_____
Phone Number:_____
Referred by:_____
How did you hear about us? _____

List of all medical conditions:
1._____
2._____
3._____
4._____
5._____

Medication currently taking: (Name of medication, dose, frequency)
1._____
2._____
3._____
4._____
5._____

Circle Family History:
Asthma Allergies Eczema Diabetes Stroke Heart Attack High Blood Pressure
High Cholesterol Cancer Glaucoma Arthritis Kidney Disease Thyroid

Other physicians/ specialist currently seeing & reason:
1._____
2._____
3._____

Allergies:_____

History of past surgeries:
Date: Reason for surgery: Hospital:
1._____
2._____
3._____

Vaccines up to date : *Yes No*
Please give the front desk vaccines records to be copied

Preferred method of contacting patient:
Home phone:_____ Mail:_____
Email:_____ Cell:_____

Good Life Medical Group

3650 East South Street
Suite #204
Lakewood, CA 90712
Tel:(562) 602-8841

5451 La Palma Avenue
Suite #16
La Palma, CA 90623
Tel: (562) 602-8841

www.goodlifemedicalgroup.com

Cancellation and No show policy
Effective 10/01/2014

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide a minimum of 24 hour notice. Please call our office to speak with our scheduling department **during office hours only** to cancel or reschedule your appointment. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are canceled, with less than 24 hours notification will be subject to a **$20.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an appointment will be considered as **NO SHOW.**

Cancellation charges are not covered by insurance and are due and payable prior to any appointments.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (562) 602-8841.

_____

Patient Name [Print]

_____ _____

Patient Signature Date

Notice of Privacy Practices Acknowledgment

Good Life Medical Group Inc

I understand that, under the Health Insurance portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name:_____

Patient Representative:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices" but was unable to do so, as documented below:

Date:	Initials:	Reason:

GOOD LIFE MEDICAL GROUP

Dear Patient,

Internet has revolutionized the way we communicate. We are shifting the way we communicate with our patients form phone model to internet model for a quicker and more meaningful responds through a secured patient portal.

Through this safe portal, you will be able to:

1) leave message to and receive message from our physician, physician assistant, nursing staff and billing personal;
2) make appointments through the portal anytime of the day
3) check your lab results and keep a copy on your own
4) tons of medical knowledge about how to get healthy
5) tons of information about you medical problems
6) what to do when you are sick
7) request for lab works
8) request for referrals
9) request for refills of your medications
10) Look up benefits and potential side affects of your medication

Please write down your e-mail address in the space below and hand it back to our receptionist, you will received the internet address of our portal, user name and password at the end of the visit from our receptionist.

patient(s)'s name(s): _____

patient or parent's e-mail address: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/ mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

I hereby authorize:

PERSON / AGENCY: _____

ADDRESS: _____

_____

TEL : _____ FAX: _____

RELEASE TO:

Name: GOOD LIFE MEDICAL GROUP TEL: (562)602-8841 FAX: (562)602-8843

ADDRESS: 3650 E. South street Suite #204, Lakewood CA 90712

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax or other electronic methods.

The medical information/ records will be used for the following purpose:

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
☐ Limited to the following medical information:

I also consent to the specific release of the following records:

Drug / Alcohol/ Substance Abuse: _____ (initial) HIV Diagnosis / Treatment _____ (initial)

Psychiatric/ Mental Health _____ (initial) Genetic Information _____ (initial)

Tests for Antibodies to HIV _____ (initial)

Duration This authorization shall be effective immediately and remain in effect until _____.

Restrictions

Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient or legal guardian Relationship if other than patient

_____ _____

Patient's name (PRINT) Date

_____ _____

Patients Social Security Number Patients Date of Birth

_____ _____

Witness Name Witness Signature

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Minor Consent

We, the undersigned parents of _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of any staff physician of Good Life Medical Group, whether such diagnosis or treatment is rendered at the office of said physicians or at a licensed hospital. We further authorize said physicians to exercise their discretion in authorizing the disposal of any severed tissue or member. It is understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage _____(name of person(s) into whose care minor is entrusted)and said physicians to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain effective until _____, unless sooner revoked in writing delivered to said physicians or said person(s) entrusted with the care of said minor.

_____ _____
Parent Signature Date Signed

_____ _____
Legal Guardian Signature Date Signed

_____ _____
Staff Member Date Received