



PATIENT REGISTRATION FORM

NEW PATIENT  UPDATE  Doctor: \_\_\_\_\_ Account: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Please indicate, in the boxes below, which order you would like us to contact you (1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> choice)

Home Phone # \_\_\_\_\_  Cell Phone # \_\_\_\_\_  Alternate Phone # \_\_\_\_\_

Social Security \_\_\_\_\_ Verified \_\_\_\_\_ Marital Status \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Local Friend or Relative Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

This information **MUST** be supplied.

Emergency Contact Other than Husband \_\_\_\_\_  
Name Relationship Phone

Full Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_  Family  Friend  Physician  Insurance  Other

PRIMARY INSURANCE INFORMATION

Insurance Co Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to PT \_\_\_\_\_

Identification No \_\_\_\_\_ Group No \_\_\_\_\_

Effective Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

SECONDARY INSURANCE INFORMATION

Secondary Insurance Co Name \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to PT \_\_\_\_\_

Identification No \_\_\_\_\_ Group No \_\_\_\_\_

Effective Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Insured Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Rel to PT \_\_\_\_\_ Sex \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Responsible Party Employer \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Temecula Valley OB/GYN Medical Associates, Inc. to examine and treat the above patient and will assume full responsibility for payment of all services. In the event of default, I also agree to pay for collection costs and attorney's fees that may be required to effect collection of the amount. The undersigned hereby authorizes Temecula Valley OB/GYN Medical Associates, Inc. to furnish necessary information to the involved insurance company, and further authorizes and assigns payment and surgical benefits due under the insurance policy.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_



Temecula Valley OB/GYN  
Medical Associates, Inc.

OBSTETRICS • GYNECOLOGY • INFERTILITY

Medical Center Drive, Suite 100  
Murrieta, CA 92562  
(951) 677-4748 FAX (951) 677-2926

## PLEASE BE ADVISED

Temecula Valley OB/GYN bills an office visit to you/your insurance if you have an injection, pregnancy test or urinalysis. Per CPT guidelines, a code of 99211 may be charged for management of an established patient that may, or may not, require the presence of a physician.

I HAVE READ THE ABOVE IN ITS ENTIRETY AND AGREE TO BEAR FULL FINANCIAL RESPONSIBILITY IN THE EVENT THAT MY HEALTH PLAN FAILS TO REMIT CLAIM REIMBURSEMENT.

\_\_\_\_\_  
PATIENT'S NAME (PLEASE PRINT)

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE

*"A Practice Specializing in Women's Health Care"*

Timothy Elfelt, MD

Joseph Glaser, MD

Debra Lebo, DO

Charles Yang, MD

Tammy Hayton, MD

Lorna Laney, RNP

Nancy Ferrell, RNP

Linda Leon, RNP



Account # \_\_\_\_\_

Acknowledgement of Having Read the HIPAA Privacy Notice Notebook

Our HIPAA Privacy Notice Notebook is in each exam room. As you are waiting for the Doctor, please read it. After you have finished, hand this signed sheet to the nurse and she will place it in your chart. Thank you.

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have read the HIPAA Privacy Notice Notebook for the medical practice of Temecula Valley OB/GYN Medical Associates, Inc. I am aware that if I would like a copy of the Privacy Notice, I can request it at the front desk.

\_\_\_\_\_  
Name of Patient (Print or Type)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient

*“A Practice Specializing in Women’s Health Care”*

Timothy Elfelt, MD      Joseph Glaser, MD      Debra Lebo, DO      Charles Yang, MD      Tammy Hayton, MD  
Lorna Laney, RNP      Nancy Ferrell, RNP      Linda Leon, RNP



## PATIENT RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPAA), this office has established procedures to make your identity and medical records secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record, a signed acknowledgement that you have read your rights and responsibilities as patients and that you understand them. Please contact the office staff if you have any questions.

### PATIENT RIGHTS



### PATIENT RESPONSIBILITIES

- To receive service within a reasonable period of time.
- To receive medically necessary services.
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have all medical and personal records treated as confidential.
- To participate in treatment decisions
- To refuse treatment.
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical records subject to legal restrictions and reasonable copying charges.
- To request review of your medical records by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.

- Having appropriate identification, insurance membership cards, coverage stickers, etc., at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or Co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship of a minor being treated.
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.
- If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding lab results and/or appointments on your answering device, or with another person who answers the phone?  YES  NO
- What is the best time of day to reach you? \_\_\_\_\_
- Where do you prefer to receive calls?  
 Home  Work  Cell  Pager

**Please sign and return this form to the front desk**

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date





**Please read the following financial policies of this office:**

NOTE: YOU WILL RECEIVE A SEPARATE BILL FROM THE LABORATORY FOR ANY LABORATORY SERVICES ORDERED (I.E., PAP SMEAR, URINALYSIS, BIOPSIES, CULTURES, BLOOD WORK, ETC.). **THESE CHARGES ARE NOT INCLUDED IN OUR BILL.** IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY FOR PAP SMEARS, BLOOD WORK, ETC., YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE BEFORE THE END OF YOUR APPOINTMENT.

**PRIVATE INSURANCE:** As a courtesy, we will bill your insurance company. We will, however, collect all percentages and/or deductibles at the time of your visit. If your insurance company requires their insurance claim form be utilized, rather than the universal HCFA 1500, it will be the patient’s responsibility for providing the form prior to their office visit. If such a form is unavailable, then we will collect all charges and then you will be responsible for billing your insurance company.

**MEDICARE:** This office will bill for all of your charges. Please show your Medicare card at the window. We ask that you pay any Medicare deductible that has not been met and your 20% Medicare co-payment at the time of your visit. You will receive an itemized bill which, when attached to the Explanation of Medicare Benefits, will provide your secondary insurance with sufficient information to process your claim. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. If you find yourself having to bill your secondary again, at your request, we will assist you with any information you need.

**SURGERY:** The office will bill for all surgery charges. Please assign authorization of payment directly to the physician. Prior to your surgery, please make arrangements for payment of any deductibles and/or co-payments. If you are not covered by insurance, payment in full will be expected on the day of your pre-operative appointment. Please be aware that there may be an assistant fee, anesthesiologist fee, laboratory fee, and radiologist fee, etc.

**PREFERRED PROVIDER ORGANIZATIONS (PPO or HMO):** If you are covered by an insurance company that we are contracted with, please present your membership card at the front desk. We will bill your insurance company. Any co-payment will be expected at the time of your visit. Please be aware that a prior authorization may be necessary for your visit and must be obtained prior to your visit. Prior authorization is a requirement of many HMO’s and their procedures and policies MUST be followed.

**SECONDARY INSURANCE:** Our office will bill your secondary insurance as long as the secondary allowable is greater than the primary allowable. Our office will bill your secondary insurance as a courtesy to you one time. If your secondary insurance does not respond to our billing, we will transfer the remainder of the charge to you. At your request, we will assist you with any information you may need to bill your secondary again.

**CASH:** If you do not have insurance, you will be expected to make payment at the time of service. Please stop at the front desk after each Gynecological or Obstetrical visit.

**ALL OBSTETRICAL PATIENTS:** An account will be established on your first visit. If you have pregnancy health insurance coverage it will not be billed until you have delivered. However, any additional fees not included in your obstetrical care, such as ultrasounds, are due and payable at the time of service. You will also be responsible for all co-payments and deductibles to be paid in full by your 30<sup>th</sup> week of pregnancy. Payment arrangements should be arranged on your first visit. If you are a member of a PPO or HMO, your co-payments will be expected at each visit, if applicable. An obstetrical contract will be generated and explained to you at check out.

*If you have any questions, please feel free to stop at the front desk. We are here to help you in any way possible.*

**I have read the above information and understand my financial obligation to Temecula Valley OB/GYN Medical Associates, Inc.**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



### Health Systems Update

**Patient Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Important:** In order to provide the highest quality of health care possible, it is important that we have the following information. Please complete this form as accurately as possible. If you do not understand the question, please ask for assistance. Thank you.

**Please describe the reason(s) for this visit:** \_\_\_\_\_

**Do you have any questions, problems, symptoms or concerns that you would like to discuss with us today?**

***Please mark the ones that are chronic problems or have changed since you were last seen.  
Thank you.***

**CONSTITUTIONAL**

- Fever
- Chills
- Weight loss or gain
- Fatigue

**EAR, NOSE & THROAT**

- Sinusitis
- Hearing Loss
- Ringing in the ears
- Sores

**EYES**

- Double vision
- Blurry vision
- Need for glasses
- Glaucoma

**CARDIOVASCULAR**

- Heart attack
- Chest pain
- High blood pressure
- Palpitations
- Leg swelling

**GASTROINTESTINAL**

- Loss of appetite
- Nausea
- Vomiting
- Abnormal bowel movement
- Pain

**NEUROLOGICAL**

- Stroke or TIA
- Headaches
- Dizziness
- Seizures
- Loss of balance

**RESPIRATORY**

- Shortness of breath
- Asthma
- Coughing
- Spitting up blood

**URINARY**

- Frequent or painful urination
- Incontinence
- Frequent UTI
- Blood in urine

**PSYCHOLOGICAL**

- Memory loss
- Depression
- Insomnia
- Nervousness

**ENDOCRINE**

- Diabetes
- Thyroid Problems
- Excessive thirst or urination

**MUSCULOSKELETAL**

- Joint pain or stiffness
- Weakness
- Injury or surgery
- Swelling

**SKIN/BREAST**

- Rashes
- Ulcers
- Nail Change
- Breast pain/ lump / discharge

**HEMATOLOGIC**

- Bleeding or bruising tendency
- Phlebitis (infection of the injection site)
- Blood clots in legs
- Transfusions
- 
- None of the above

**GYNECOLOGICAL**

- Pain with intercourse
- Irregular menses
- Pelvic pain

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