MISSION RANCH PRIMARY CARE INC.

Bryan G. Furst, M.D. • J. Ross Nayduch, M.D.
Marcia F. Nelson, M.D. • A. M. Corky Rey, M.D.
Jennifer L. Parrish, M.D., Inc. • James A. Westcott, M.D.
Stephen Peterson, M.D. • Debra Peterson, PA-C • Mark K. Weeber, M.D.

To All Mission Ranch Primary Care Patients:

At Mission Ranch Primary Care we strive to provide the best possible customer service. As a part of this, we ask that you fill out this paperwork and return it to our office, **along with a copy of your insurance card** (or proof of insurance) as soon as possible so we can schedule your appointment.

Please contact your insurance carrier **before** your appointment to ensure that our doctor is contracted with your insurance plan. If you have an HMO, please be sure your doctor at Mission Ranch Primary Care is listed on your HMO card. If it is not listed, please call your insurance provider's Member Services (the phone number is listed on the back of the card) **before** your first appointment.

Please check in for your appointment 10 minutes early and bring any medication you are currently taking in the bottles to your appointment. We ask that you call at least 24 hours prior to your appointment for any cancellations or if you need to reschedule.

Thank you,

Mission Ranch Primary Care Inc.

NOTICE TO CONSUMERS
Medical Doctors are licensed and regulated by
The Medical Board of California
(800) 633-2322 or www.mbc.ca.gov

114 Mission Ranch Blvd., Ste. 10 • Chico, CA 95926 • Phone: (530) 894-0500 • Fax: (530) 345-2532

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Welcome to Mission Ranch Primary Care! We are happy that you have chosen one of our physicians to be your primary care doctor and we look forward to providing you with excellent care. Please take a moment to read the following policies. Please save this page for future reference.

Prescription Refills

You must call your pharmacy, rather than our office, to request refills of your medication(s); your pharmacy will then contact us regarding your request. Please allow 48-72 hours for processing your refill request. To avoid running out of your medication(s), please plan ahead and call in your refill request 3-5 working days before taking your last dose. For refill medication(s) that are not on your health insurance plan's formulary, please allow at least one week for processing your request.

Written Prescriptions, Mail Order Prescriptions and Triplicates

Please allow 5 working days to complete your request for any type of written prescription. This includes controlled medications (triplicates) that must be hand carried to the pharmacy as well as mail order prescriptions. Please call in your request at least 3-5 days before taking your last dose. For refills of medication(s) that are not on your insurance plan's formulary, please allow at least one week for processing your request. We may not be able to fax all mail away prescriptions. We will notify you when your written prescription is ready to be picked up. Please request mail away refills/prescriptions 10-14 days before your last dose.

Medications Requiring Prior Authorization

Please allow us 7-10 working days to complete requests for medications that require prior authorization from your insurance company. Please notify us 10-14 days before taking your last dose.

Insurance Referrals/Prior Authorization

Please allow 7 working days for us to complete a request for any non-emergent referrals/authorizations. (Example: referrals for visits to specialists, diagnostic tests, clinical procedures, etc.) Please notify our office as soon as possible of the need for an authorization, so we may process it in a timely manner.

Worker's Compensation

We **do not** accept worker's compensation cases, nor do we accept designation as personal physicians for any worker's compensation cases/claims.

Thank you in advance for your cooperation with the above policies.

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Dear Patients:

This is to inform you that the physicians at Mission Ranch Primary Care utilize *hospitalists* to care for their patients who require hospitalization. A hospitalist is a physician who assumes the care of a patient during their stay at the hospital and then turns the care over to the patient's primary care physician upon discharge.

The hospitalist group is led by well-respected local physicians who have chosen to dedicate themselves to the care of the hospitalized patient. Because the majority of the care required by our patients is outside the hospital setting, Mission Ranch Primary Care decided to partner with the hospitalists so that our doctors can focus on where our patients primarily need us—in the office.

Please be assured that our doctors remain in close communication with the hospitalist staff so that "continuity of care" is preserved and your transition home from a hospital stay goes smoothly.

Thank you,

Mission Ranch Primary Care Inc.

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Mission Ranch Primary Care

Patient's Name: _____
First Middle Last

Nickname/Preferred Name: _____ **Male / Female** (circle)

Race/ Ethnicity: _____ Primary Language Spoken: _____ Decline to State ☐

Date of Birth: _____ Age: _____ **Marital Status:** S M W D Sep Minor
(circle)

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Main Contact Number: ( ) _____ SS#: ___-___-___ Driver's Lic. #: _____

Alternate Number: ( ) _____ E-Mail Address: _____

OKAY TO LEAVE MESSAGES ON PROVIDED CONTACT NUMBERS? **BOTH MAIN ALTERNATE**

Employed by: _____ Occupation: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) _____ OKAY TO LEAVE MESSAGES AT WORK? **YES NO**

Spouse's Name or (***IF PATIENT IS A MINOR***) Parents' Name: _____

Employed By: _____ Occupation: _____

Phone Number: ( ) _____

EMERGENCY CONTACT:

Nearest Relative/Close Friend ***NOT*** Living With You: _____

Phone Number: ( ) _____ Relationship to Patient: _____

Please present your insurance card(s) with this completed form.

Primary Insurance: _____ Secondary Insurance: _____

ASSIGNMENT OF BENEFITS-CONSENT FOR TREATMENT-RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and/or any other plan to Mission Ranch Primary Care. This assignment will remain in effect for one year from date signed. A scan and/or photocopy of this assignment will be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release information necessary to secure payment. I hereby authorize Mission Ranch Primary Care to perform any medical treatment deemed necessary.

Signature: _____ **Date:** _____

Name: _____ Date of Birth: _____ Date: _____

Family History

	D.O.B.	If living, list health problems, i.e. heart disease, diabetes, cancer (including type)	Age	If deceased, list cause of death or major health problems
Father				
Mother				
Siblings 1. 2. 3.				
Spouse				
Children 1. 2. 3. 4.				

When was your last (actual or best estimate of date):

Preventive visit/ annual physical/ screening labs (which lab?)_____

Vaccinations: Tetanus/Pertussis (Whooping cough, Td/Tdap) _____ Flu _____

Pneumonia _____ Shingles/Zoster _____

Screening tests (please include result, facility location, and planned follow-up, if applicable):

Colonoscopy _____ DEXA (bone density test) _____

Women: Mammogram _____ Pap _____ Last Menstrual Period _____

Please list all health problems: _____

_____

_____

_____

Please list any surgeries and hospitalizations, including date: _____

_____

_____

_____

Smoking history (current/past, amount, quit date _____ Avg. weekly alcohol consumption _____

Regular exercise (type and how often)? _____

Hobbies: _____

List any allergies (medication or other) and the reaction: _____

_____

_____

Name: _____ Date of Birth: _____ Date: _____

Please indicate if you have trouble or concerns with the following (including a brief explanation):

Yes	No		
		Neurologic:	
☐	☐	Frequent headaches	_____
☐	☐	Change in vision	_____
☐	☐	Change in hearing	_____
☐	☐	Dizziness	_____
☐	☐	Difficulty walking	_____
☐	☐	Speech difficulty	_____
☐	☐	Numbness or tingling	_____
		Cardiopulmonary:	
☐	☐	Chronic cough	_____
☐	☐	Shortness of breath	_____
☐	☐	Chest pain	_____
☐	☐	Heart palpitations	_____
☐	☐	Fainting	_____
☐	☐	Swelling of the legs/feet	_____
		Gastrointestinal:	
☐	☐	Unintended weight loss	_____
☐	☐	Difficulty swallowing	_____
☐	☐	Heartburn, indigestion, reflux	_____
☐	☐	Abdominal pain	_____
☐	☐	Frequent nausea/vomiting	_____
☐	☐	Frequent diarrhea	_____
☐	☐	Frequent constipation	_____
		Genitourinary:	
☐	☐	Pain with urination	_____
☐	☐	Frequent urination	_____
☐	☐	Incontinence (trouble holding urine)	_____
☐	☐	Getting up at night to urinate	_____
☐	☐	Blood in urine	_____
☐	☐	Sexual concerns	_____
		Musculoskeletal:	
☐	☐	Muscle or joint pain	_____
☐	☐	Muscle weakness	_____
		Dermatologic:	
☐	☐	Rash	_____
☐	☐	Warts	_____
☐	☐	Concerning or changing moles, bumps, lesions	_____

Please list any specific concerns you would like to address in the upcoming visit: _____

_____

_____

_____

Name: _____ Date of Birth: _____ Date: _____

Prescription and Non-Prescription Medications

(including vitamins and other supplements)

☐ **I am not taking any meds or supplements**

Medication	Strength	Frequency (how often)	Indication (diagnosis/reason)

****Please attach a separate list if medications exceed the space provided****

Current and Recent Physicians

(and other health practitioners or therapists)

Physician Name	Specialty (and reason seen)

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Pharmacy Information

You must contact your local pharmacy with ALL refills. They will contact our office with refill information. Please allow 48-72 hours for processing your refill request. Please request refills 3-5 days before your last dose.

We may not be able to fax all mail away prescriptions. Please allow 5 business days for written prescriptions. We will notify you when your prescription is ready to be picked up. Please request mail away refills/prescriptions 10-14 days before your last dose. **Please provide us with your mail away pharmacy's fax number.**

Local Pharmacy: _____

Location: _____

Mail Away Pharmacy: _____

Medication History Consent Form

By signing below, I voluntarily consent to provide Mission Ranch Primary Care access to and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years.

I understand that this Medication History Consent will be valid and remain in effect as long as I receive services from Mission Ranch Primary Care, unless revoked in writing.

I certify that I have read this form and/or it has been read to me.

_____ _____
Signature of Patient/Legally Authorized Representative **Date**

_____ _____
Print Name (Patient) **DOB**

_____
Relationship to Patient (if Patient is not signing)

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Portal Authorization

Mission Ranch Primary Care has established a Patient Portal. This is a secure website that can be used to:

- Communicate with our practice
- View your Personal Health Records
- Review your lab results
- Request appointments
- Request prescription refills
- Manage your personal information

Your email address will be required to enable access to our Portal. Our office will provide you with a secure username and temporary password. Your email address will be the primary method of communication through our Portal which may include personal information.

Note: We are unable to provide Portal access to teenagers or their parents/guardians between the minor's 12th birthday and 18th birthday.

Name: _____

Yes, I would like to be set up with the Patient Portal **Initials**_____

Email address: _____

No, I would not like to be set up with the Patient Portal. **Initials**_____

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Release of information according to HIPAA, notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, notice of Privacy Practices, your doctor and the staff at Mission Ranch Primary Care must have WRITTEN permission to speak with any other person, such as your spouse, caregiver, family member, friend, etc. regarding your care.

You may designate the person(s) of your choice in the spaces provided below. In doing this, you are giving our office permission to speak to these individuals regarding your treatment, test results, billing, appointments, prescriptions, etc. **Anyone not indicated on this form will not be given access to your information.**

This form does not apply to other treating physicians, only to family and friends.

This form is effective for any services delivered and will be effective until written notice is given to void this agreement.

I, _____, give Dr. _____and his/her staff authorization to communicate with the following person(s) in regards to my care:

Name	Relationship	Phone

I do not wish to designate anyone. _____ (Initials)

_____ _____

Signature **Date**

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- **Mission Ranch Primary Care is unable to accept new Medi-Cal or CMSP patients at this time.** Should you obtain Medi-Cal or CMSP as your primary insurance while being treated by this office, we will no longer be able to accept you as a patient at Mission Ranch Primary Care.

- **Patients are responsible for verifying that their physician is a contracted provider and/or services provided by our office are covered under their insurance plan.** If your physician is not a preferred provider, or a service is not covered, then you will be responsible for any charges incurred.

- **Co-pays are due at the time of service.** Please be prepared to pay your co-pay at that time.

- You will be asked to update certain paperwork **every year**, (such as your face sheet, health history, etc.) and provide a copy of your insurance card(s). Please be prepared to provide this information when asked.

I have read and understood the above statements.

_____ _____

Signature **Date**

_____

Print Name

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RECEIPT OF *Notice of Privacy Practices*

WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of Mission Ranch Primary Care's *Notice of Privacy Practices.*

Signature **Date**

Print Name

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Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION AS A PATIENT OF THIS PRACTICE MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI.
- Your privacy rights in your IIHI.
- Our obligations concerning the use and disclosure of your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Office Manager
114 Mission Ranch Blvd., Ste 10
Chico, CA 95926
(530) 894-0500

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use

your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or device they may be using has been recalled
    - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions;

or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    - Concerning a death we believe has resulted from criminal conduct
    - Regarding criminal conduct at our offices
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
7. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
9. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.** Your request must describe in a clear and concise fashion:
   (a) The information you wish restricted;
   (b) Whether you are requesting to limit our practice's use, disclosure or both; and
   (c) To whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.**
7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Office Manager, 114 Mission Ranch Blvd., Ste 10, Chico, CA 95926.**