31493 Rancho Pueblo, Suite 204, Temecula CA 92592
Phone: 951-303-6158 Fax: 951-303-8492

NOTICE TO OUR PATIENTS

Thank you for choosing The Family Practice of Dr. Gisi as your healthcare provider. We look forward to providing an office environment and provider relationship that meets you and/or your family's medical needs.

Items to bring to your first appointment:

1. Driver's license or other photo identification.
2. All insurance cards.
3. Co-pays or payment in full at the time of your visit if you are not covered by insurance.
4. Actual bottles of all medications (prescribed and over the counter) that you are currently taking.

NO SHOW POLICY

As a courtesy to our patients, our staff calls patients prior to their scheduled appointment to remind them of the appointment date and time. We perform these calls as a courtesy to our patients and to allow us the opportunity to reschedule the time slot should the appointment not be necessary. Please phone at least 24 hours in advance if you will not be able to keep your scheduled appointment. We are committed to ensuring your access to same day professional care. For that reason, we have implemented a "No Show Policy".

Missed appointments or last minute cancellations will be subject to a $25.00 fee, which will be required to be paid in full prior to the scheduling the next appointment.

For the purposes of this policy, a no-show appointment is defined as follows:

1. An appointment which is missed by the patient without any advance notice.
2. An appointment that is cancelled less than 24 hours prior to the scheduled appointment time.
3. An appointment in which the patient arrives 10 minutes or more beyond the scheduled appointment time.

Failure to show for the initial "new patient" appointment may eliminate your opportunity to establish care as a new patient.

Paperwork Forms and Fee's

Please understand that there will be a minimum fee of $25.00 for any paperwork from 3rd parties that need to be filled out by Dr. Gisi or staff.

RX REFILL POLICY

Our policy is to refill patient prescriptions within 72 (business) hours of receiving the request. Please do not wait until you are completely out of medication or you will likely do without until the refill can be processed.

How to Request a Prescription Refill:

1. Call your pharmacy 3-5 days before you run out. If you use a mail order service (Express-Scripts, RX Solutions), contact them at least 1-2 weeks prior.
2. Ask your pharmacist to fax us a prescription refill request. Once received, our office may authorize a refill if appropriate.
3. If you have not been in our office recently, refills may be denied. Especially if you have specific metabolic conditions.

______________________________ ______________ ________________
Patient Name: Date: Received By:

____
Patient Signature or Patient Representative Relationship (If Signed by Other than Patient)

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Patient Information

Date: ____________________

Patient Name: ____

Date of Birth: __________________ Age: __________________ Gender: ☐ Male ☐ Female

Street Address: ____ City/State/Zip: ________________________________

Mailing Address: ____ City/State/Zip: ________________________________

Home Phone: (_____)_______________ Cell Phone: (______)________________ Work Phone: (_____)_________________

Email Address: ____

Would you like to sign up and have access to our patient portal? ☐ No ☐ Yes (Please provide a valid email address)

Demographic Information

The American Recovery and Investment Act of 2009 (ARRA) require medical providers to collect patient race, ethnicity, and language data. Your and ethnicity are to be recorded in accordance with the Office of Management and Budget (OMB) standards.

Your Race

☐ American Indian or Alaska Native ☐ African American ☐ Asian ☐ Caucasian

☐ Filipino ☐ Hispanic/Latina ☐ Native Hawaiian or Pacific Islander ☐ Other: __________________________

Preferred Language: __________________________________

Marital Status

☐ Single ☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Domestic Partner ☐ Other: ___________________________

Insurance Information

Name of Primary Insurance: ____________________________ Primary Insurance Holder Name: ________________________

Member ID# ____ Group# ____

Patient Relationship to Primary Insurance Holder: ____

Pharmacy Information

Local Pharmacy

Name: _____________________________________

Address: ___________________________________

Phone: (_____)______________________________

Mail Order Pharmacy

Name: _____________________________________

Address: ___________________________________

Phone: (_____)_____________________________

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Health History for New Patients

Patient Name: ____ Date: _____________________________

Please list any medical conditions during the past 10 years that required hospitalization or treatment for a period more than 2 weeks.

____

____

Have You ever been treated for a traumatic injury? YES ____ NO____

If yes, please specify:

Year: __________________ Type of Injury: ______________________________How injury occurred: ______________________

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Year: __________________ Type of Injury: ______________________________How injury occurred: ______________________

FAMILY HISTORY

Please indicate if a family member has been treated for any of the following:

Hypertension	YES ____	NO____
Diabetes	YES ____	NO____
High Cholesterol	YES ____	NO____
Cancer (Type) _______________________	YES ____	NO____
Stroke	YES ____	NO____
Heart Disease	YES ____	NO____
Depression	YES ____	NO____
Other (Specify) ______________________	YES ____	NO____

SOCIAL HISTORY

Occupation: ____

Have you traveled outside the US in the past 5 years? YES ____ NO____

Date: ________________________________ Location: ____

Date: ________________________________ Location: ____

LIFESTYLE

Did you or do you smoke? YES ____ NO____

Packs per day _______________________ For how long ____

When did you quit? ____

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Health History for New Patients

Do you drink alcohol? YES ____ NO____

How often? ____

Have you ever used or are currently using drugs? YES ____ NO____

Explain: ____

MEDICATIONS
Please list all prescriptions/medications you are taking.

Medication: ___________________________ Dosage: ___________________ Reason: ____________________________

Medication: ___________________________ Dosage: ___________________ Reason: ____________________________

Medication: ___________________________ Dosage: ___________________ Reason: ____________________________

Medication: ___________________________ Dosage: ___________________ Reason: ____________________________

Medication: ___________________________ Dosage: ___________________ Reason: ____________________________

Please list any vitamin/supplements you are taking.

Vitamin/Supplement: ____________________________ Vitamin/Supplement: ____________________________

Vitamin/Supplement: ____________________________ Vitamin/Supplement: ____________________________

Vitamin/Supplement: ____________________________ Vitamin/Supplement: ____________________________

Please list any medication allergies.

Medication: ____________________________________ Reaction/Symptom: _____________________________

Medication: ____________________________________ Reaction/Symptom: _____________________________

SURGERIES
Please list any surgeries you have had.

Type: _________________________________ Date: ______________________ Hospital/Facility: ________________________

Type: _________________________________ Date: ______________________ Hospital/Facility: ________________________

MEN ONLY
When was you last PSA? Date: ______________________________

WOMEN ONLY
How many pregnancies have you had? ______________ Years: ____

Complications: ____

Have you gone through menopause? YES ____ NO____

Last mammogram: Date: _______________________ Normal? YES ____ NO____

Last PAP smear: Date: _______________________ Normal? YES ____ NO____

Sylvia A. Gisi, M.D.
FAMILY PRACTICE

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Health History for New Patients

REVIEW OF SYMPTOMS

Please describe your general health: Excellent: ________ Good: _________ Fair: _________ Poor: _________

Please check YES or NO to the following health questions, past or present.

Head and Neck

Eye Disease / injury or impairment: YES ____ NO____
Ear disease / injury or impairment: YES ____ NO____
Nose sinus, mouth, throat complaints: YES ____ NO____
Enlarged glands: YES ____ NO____

Cardiovascular

Chest pain or angina: YES ____ NO____
Heart murmur: YES ____ NO____
Heart attack: YES ____ NO____
Heart surgery: YES ____ NO____
Heart valve problem: YES ____ NO____
Heart palpitation or fluttering: YES ____ NO____
Swelling of ankles feet or hands: YES ____ NO____
Varicose veins: YES ____ NO____
High blood pressure (hypertension): YES ____ NO____
Peripheral vascular disease: YES ____ NO____

Gastrointestinal

Ulcer or other stomach problems: YES ____ NO____
Indigestion or pain after eating: YES ____ NO____
Appendicitis: YES ____ NO____
Liver disease, hepatitis, or Jaundice: YES ____ NO____
Gallbladder disease: YES ____ NO____
Hemorrhoids: YES ____ NO____
Rectal Bleeding: YES ____ NO____
Persistent change in bowel habits: YES ____ NO____

Genitourinary

Bladder or kidney infections: YES ____ NO____
Blood in urine: YES ____ NO____
Kidney Stones: YES ____ NO____
Difficulty urinating: YES ____ NO____
Incontinence: YES ____ NO____
Impotence: YES ____ NO____

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Health History for New Patients

Hematopoietic

Blood Clots:	YES ____	NO____
Easy bruising:	YES ____	NO____
Anemia:	YES ____	NO____
Do you take aspirin?	YES ____	NO____
Dou you take blood thinners?	YES ____	NO____

Metabolic / Endocrine

Diabetes:	YES ____	NO____
Sugar in urine:	YES ____	NO____
Do you take steroids?	YES ____	NO____
Thyroid goiter:	YES ____	NO____

Musculoskeletal

Bane fractures:	YES ____	NO____
Arthritis:	YES ____	NO____
If YES Type: _______________________		

Neurologic

Fainting spells / Loss of consciousness:	YES ____	NO____
Convulsions / Seizures:	YES ____	NO____
Paralysis:	YES ____	NO____
Dizziness:	YES ____	NO____
Frequent and/or severe headaches:	YES ____	NO____

Physiological

Depression:	YES ____	NO____
Anxiety:	YES ____	NO____
Sleep disorders:	YES ____	NO____
Hallucinations:	YES ____	NO____

Respiratory

Chronic or frequent cough:	YES ____	NO____
History of tuberculosis:	YES ____	NO____
Pneumonia:	YES ____	NO____
Emphysema / COPD:	YES ____	NO____
Asthma:	YES ____	NO____

Skin

Skin cancer:	YES ____	NO____
Other skin disorder / disease:	YES ____	NO____

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Adult TB Exposure Risk Assessment

Evaluation question are to determine if Montoux tuberculin skin test (TST) is indicated

Name: _________________________________ Medical Record: _______________

Age: _______________ DOB: _______________ Date of Service: _______________

1. Have you or anyone you see regularly been diagnosed or suspected of being sick with an active disease? YES_____ NO_____
2. Do you have family members or frequent visitors who were born in high TB prevalence countries? (Asia, Africa, Latin America, Eastern Europe) YES_____ NO_____
3. Were you born in or travel to high TB prevalence countries? (Asia, Africa, Latin America, Eastern Europe) YES_____ NO_____
4. Do you live in/out of home placement such as foster care or residential facilities? YES_____ NO_____
5. Do you have HIV infection or other immunosuppressive condition(s)? YES_____ NO_____
6. Do you live with someone with HIV suppositivity? YES_____ NO_____
7. Do you live or frequently visit persons that have been incarcerated in the last 5 years? YES_____ NO_____
8. Do you live among or been frequently around individuals who are homeless, migrant workers, or residents in a nursing home? YES_____ NO_____
9. Do you consume alcoholic beverages? YES_____ NO_____

HEALTH CARE INSTRUCTIONS:

Administer the Montoux tuberculin skin test (TST) to all adults who have any of the above risk factors (Indicated by a yes response) UNLESS;

1. The patient has a previously DOCUMENTED* positive Mantoux TST, or
2. The patient has had a TDT within the last year.

*Documented = record indicating date of Mantoux and the millimeter results.

Health Care Worker: ____________________________ Date: ______________________

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HIPAA Compliance Patient Consent

Patient Name: ____ Date: __________________________

Under the Health Insurance Portability and Accountability Act of 1994("HIPAA"), The Family Practice of Dr. Sylvia A. Gisi does not release confidential medical information regarding your treatment to family members or friends, except for a parent/legal guardian or other persons authorized by the patient.

Exceptions Caused by Circumstances:

If you bring another person into the exam room during a regular or emergency appointment, we will assume without objection, the person(s) is entitled to hear or receive information regarding your medical issue and/or treatment.

Notice of Privacy Practice:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Contact Authorization:

I, ____, hereby give my consent to Dr. Gisi and her staff to contact me regarding labs, x-rays, referrals, and appointments via:

(Select all the apply)

☐ Email: ____

☐ Cell Phone: (_____)______________________________ ☐ Cell Phone Voicemail

☐ Home Phone: (_____)_____________________________ ☐ Home Phone Voicemail

☐ Spouse/Significant Other Name: ____

☐ Parent / Legal Guardian Name: ____________________________________ Phone: (_____)_______________

☐ Emergency Contact Name: ______________________________________ Phone: (_____)_______________

☐ Mail: Address: _____________________________________ City/State/Zip: _________________________

☐ **DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY.**

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HIPAA Compliance Patient Consent

Prescriptions/Records Release:

If you need to pick up a prescription or require your medical records released to another person other than yourself, please list them below.

Name: ___________________________________ Relationship: ________________________ Phone: ___________________

Name: ___________________________________ Relationship: ________________________ Phone: ___________________

Name: ___________________________________ Relationship: ________________________ Phone: ___________________

In case of Emergency, who should be notified? Name: ____

Relationship to Patient: ________________________________ Contact Phone #: ____________________________________

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Any changes to this form must be made in person at the Family Practice of Dr. Sylvia A. Gisi.

____ _______________________ _____________________________
Patient Name: Date: Received By:

____ ____
Patient Signature or Patient Representative Relationship (If Signed by Other than Patient)

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FINANCIAL DISCLOSURE STATEMENT

The following disclosure is furnished in compliance with the Federal Truth-in-Lending Act.

Dr. Gisi's office shall charge a FINANCE CHARGE on any part of the "previous balance" as shown on the periodic statement from the group, which remains unpaid in excess of 90 days after the first billing of the "previous balance" at the periodic rate of 2% per month after deducting current payments and/or credits received prior to the closing (billing) date of the statement.

The ANNUAL PERCENTAGE RATE is 15% annum. There shall be in all cases a minimum FINANCIAL CHARGE of $50.00 per month. Said minimum charge may result in ANNUALPERCENTAGE RATE in excess of 15% per annum. No FINANCE CHARGE will be charged on any 'pervious balance" as shown on the periodic statement, which is paid 90 days from the first billing of the "previous balance" or on any current charges listed on the parodic statement. The FINANCE CHARGES are figured on your account by applying the periodic rate to the amount you owe at the beginning of each billing cycle. All payment received shall be first applied to any FINANCE CHARGE assessed to the account, and then to that portion of the "previous balance" which is more than 90 days unpaid and then to that portion of the "previous balance" which is less than 91 days unpaid and then to the current charges listed on the periodic statement, and finally to credit.

You may pay your entire balance at any time, however any outstanding balances must be paid prior to any future visits.

Any credit balances of $4.99 or less will be automatically adjusted to $0.00 due to the administrative costs of processing balances.

You are responsible for payment on your account regardless of insurance. Dr. Gisi's office cannot accept the responsibility for collecting your insurance claims or negotiating a settlement on a disputed claim. Notwithstanding insurance benefits that may have accrued the FINANCE CHARGES as set out above shall be assessed against all accounts, even if the account will ultimately be paid by insurance benefits. Dr. Gisi's office uses an outside billing company, and if unable to resolve any financial issues with them or have any concerns please call our office.

Dr. Gisi's office will not acquire or retain any security interest in any property to secure the payment of credit extended for services rendered, except that Dr. Gisi's office reserves the right to obtain assignment of benefits for payment of balances accrued at the group.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Printed Name: ____

Signature: ____ Date: ________________________________