



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 \$50.00 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 \$50.00 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) _____



Sylvia A. Gisi, M.D.
FAMILY PRACTICE

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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 race 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: _____

Year: _____ Type of Injury: _____ How injury occurred: _____

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? _____



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 ____



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 _____



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 ____



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.**

We do not take work compensation and ultimately it is the subscribers responsibility to ensure you are in network.



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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.

Our office does not accept worker's compensation insurance. Payment for all services is the subscribers responsibility to ensure you are in network.

Printed Name: _____

Signature: _____

Date: _____