DAVID ALONSO, MD
INTERNAL MEDICINE
BOARD CERTIFIED

David Alonso M.D.

564 Rio Lindo Ave Suite 100, Chico, Ca. 95926 530-767-3300 Fax # 530-767-3305

Welcome to our office, we look forward to meeting you and your medical needs. We hope you find our office and staff to be welcoming, kind and very professional!

You have received paperwork that is very important and will need to be completed prior to your first visit with the doctor. You have been asked to come to your appointment early to allow for this paperwork and our check in process to be completed in a timely manner. Please bring the completed paperwork along with your current insurance cards to the receptionist upon your arrival. Additionally, we will take a copy of your driver's license or ID and take a photo for your electronic record.

All co-pays are required to be paid at the time of visit. We accept cash, check or credit cards.

We require a 24 hour cancellation notice on all appointments, if this is not done you may be charged a $ 50.00 cancelation fee.

If you have any questions or concerns, please give the office a call.

We look forward to meeting you.

David G. Alonso. M.D
And staff

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Patient's Personal Information Please Print

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: Male Female. Race _____

Your Name (Last, First, MI): _____Date of Birth (mm/dd/yyyy): _____/ _____/_____

Social Security # _____-_____-_____ Home Phone: (_____) _____-_____ Cell Phone (_____) _____-_____

Work Phone: (___) _____-_____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Employer_____ Occupation _____ E-mail Address_____

Patient's/ Responsible Party Information

Relationship to Patient: ☐ Self ☐ Parent ☐ Other: _____

Name (Last, First, MI): _____ Date of Birth (mm/dd/yyyy): _____/ _____/_____

Social Security # _____-_____-_____ Home Phone: (_____)- _____-_____ Work Phone (_____)-_____-_____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Employer_____ Occupation _____

Patient's Insurance Information

Primary Insurance Company Name: _____

Address: _____City: _____ State: _____ Zip: _____

Name of Insured: _____ DOB (mm/dd/yyyy):_____ Relationship to insured: ☐ Self ☐ Spouse ☐ other: _____

Policy #: _____ Group #: _____

Secondary Insurance Company Name: _____

Address: _____City: _____ State: _____ Zip: _____

Name of Insured: _____ DOB (mm/dd/yyyy):_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other:_____

Policy #: _____ Group #: _____

Pharmacy Information

Name: _____Street:_____

If out of area, Address _____ Phone: (_____)-_____-_____

Emergency Contact

Name (Last, First, MI): _____Relationship to Patient: ☐ Self ☐ Spouse ☐ other: _____

Home Phone: (_____)- _____-_____ Work/ Cell Phone (_____)-_____-_____

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

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Provider listed above, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I herby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Patient Signature: _____

New Patient History Form

David Alonso, MD
564 Rio Lindo Ave, Ste 100
Chico, CA 95926
phone: (530) 767-3300
fax: (530) 767-3305

Please fill out the following questions to ensure that we have accurate and complete information regarding your health.

Name_____ D.O.B _____ Today's Date _____

Reason(s) for seeing the doctor today (current symptoms):_____

_____

Surgical History

Previous Surgeries: _____

_____

Past and Present Medical Illnesses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Pregnancy History: (Women)
Number of Pregnancies: _____
Number of Live Births: _____

Age at Onset of Periods: _____
Periods Last for: _____
Periods Occur Every: (days) _____

Onset of Last Periods: _____

Allergies:

_____

Other Medical Providers:

_____

Health Screening and Vaccinations:

Vaccine history:

Adult Vaccines	Date given
Tetanus:	_____
Pneumovax:	_____
Prevnar-13:	_____
Shingrix:	_____
Gardasil (HPV):	_____
Hepatitis B:	_____

Health Screening Tests:

	Date Last Performed
Mammogram:	_____
Pap smear:	_____
DEXA (Bone Density):	_____
Colonoscopy:	_____
PSA:	_____
Eye Exam:	_____

Aortic Aneurysm Screening: _____

Lung Cancer Screening (smokers): _____

Current Medication(s):

Please list all **Prescription Medications** including eye drops and inhalers

Name	Strength	Dosing Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If more space is required please attach additional list)

Please list all **Over the Counter** medications, vitamins and supplements

Name	Strength	Dosing Instructions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If more space is required please attach additional list)

Name: _____ (Please include your name on every page)

Family History:

	Living	Dead	Age	Chronic Condition(s) / Cause of Death
Mother:	☐	☐	____	_____
Father:	☐	☐	____	_____
Brothers:	☐	☐	____	_____
Sisters:	☐	☐	____	_____
Children:	☐	☐	____	_____

Other Health Problems in the Family: _____

_____

Personal History:

Occupation: _____

Education: Grade _____ College ☐ Major:_____

Smoking Status:

None

Former Smoker Quit Date: _____

Current Smoker Amount/day: _____ How long: _____

Type Cigarettes Pipe Cigars Smokeless Tobacco Marijuana

Alcohol consumption

Type: _____ Amount per week: _____

Recreational Drugs:

Type: _____ Amount per week: _____

Exercise:

Type: _____ Amount per week: _____

Seat Belt Use:

All the time Most of the time None of the time

Sexual History:

Sexually Active: Yes No

Partner preference: Men Women Both

Lifetime Number of Partners: Two or Less More than Two

Name: _____ (Please include your name on every page)

Living Arrangements / Independence:

Live with:	Alone	With Spouse	With Family		
Location:	Home	Independent Living Facility	Nursing Facility		
Need Assistance with:	None	Bathing	Dressing	Eating	Meals
	Toileting	Grooming	Walking	Transferring	
Walking Assistance:	None	Cane	Walker	Wheelchair	
Any recent falls?	No	Yes			

Other Comments or Concerns:

_____

_____

_____

_____

_____

Name: _____ (Please include your name on every page)

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Medical Records Information Authorization Release

ALL PATIENTS MUST COMPLETE AND SIGN

For your protection and privacy you will update this form once a year.

Do you give permission to release your records to other referring physicians if the case arises for medical purposes?

YES NO PATIENT INITIAL_____

If you grant permission for the release of your records to any other party for medical purposes, do we have your permission to send electronically, by fax or by mail?

YES NO PATIENT INITIAL_____

Do you have an answering machine/cell phone and do we have permission to leave a message?

YES NO PATIENT INITIAL_____

Do we have your permission to discuss your medical condition, examination and /or diagnosis with your family members for medical purposes?

YES NO PATIENT INITIAL_____

Please print first & last names of family members:

1._____ 2._____

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practice with respect to protect health information , if you have objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number .

Signature below is an acknowledgement that you have received the Notice of our Privacy Practice:

_____ _____
Print Name ***Date***

_____
Signature

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PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES

PATIENTS RIGHTS
You have the right to:

1. *Respectful and considerate care*
2. *Know the names, titles and qualifications of all who provide their care*
3. *Full consideration of privacy and confidentiality with regards to information and records of your care*
4. *Information regarding diagnoses, evaluations, treatment, and prospects for recovery in terms you can understand*
5. *Participate actively in decisions involving their health care, including information about any proposed treatment or procedure in order to give information consent or refusal. Except in emergencies, this information shall include a description of the options for treatment and the risks and advantages of each*
6. *Know the medications prescribed for you-what they are, what they are for, how to take them properly, and possible side effects*
7. *Change primary care or specialty physicians if desired*
8. *Be provided with information about your health plan*
9. *Voice concerns and make suggestions regarding the organization and / or the care provided, including being informed of grievance procedures*
10. *Examine and receive an explanation of their bills for service, regardless of the source of payment*

PATIENT RESPONSIBILITIES
You have the responsibility to:

1. *Respect the rights, property and environment of all physicians, health care professionals, employees and other patients*
2. *Know the benefits and exclusions of your insurance coverage*
3. *Supply the office with correct and up to date insurance coverage at each visit*
4. *Provide your healthcare provider with complete and accurate information about present symptoms, past illness, hospitalizations, medications and other health matters*
5. *Report unexpected changes in your condition*
6. *Clearly understand a contemplated course of action and follow the treatment plan agreed upon by you and your physician*
7. *Keep your appointment and if unable to do so, notify the office 24 hours prior to your appointment time. Failure to do so will result in a* ***$50.00 missed appointment charge***
8. *Contact your primary physician for any care needed after regular office hours*
9. *Know how to access health care services in routine, urgent and emergency situations*
10. *Engage in behaviors that promote good health, including nutrition, physical activity and health risk avoidance and seek periodic health screening evaluation as recommended by your care provider*
11. *Be responsible for meeting the financial obligations of your medical care as promptly as possible*
12. *A 48 hour notice is required for all refills. All refill requests must come from patient's pharmacy to avoid any errors. Unless it is a controlled medication that requires special authorization*

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PATIENTS ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITY

I _____, had read and acknowledged the patient rights and responsibility agreement.

_____ _____

Patient signature *Date*

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NOTICE OF HIPPA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. ***Treatment****. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.*
2. ***Payment****. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.*
3. ***Health Care Operations****. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring*

them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. ***Appointment Reminders****. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.*
5. ***Sign in Sheet****. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.*
6. ***Notification and Communication with Family****. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about information pertaining to your location, your general condition or in the event of your death. Additionally, in the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information during an emergency or disaster, even if you object, if we believe that it is necessary to respond to such personal or public emergency or disaster. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.*
7. ***Marketing****. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We may receive payment for these communications for your health plan to describe 1) a provider's participation in the health plan's network, 2) the extent of covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any other payment for these types of communications unless you have a chronic and seriously debilitating or life-threatening condition, and in that case we will tell you who is paying us, and we will also tell you how to stop them if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for that marketing activity.*
8. ***Sale of Health Information****. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it and we will stop any future sales of your information to the extent that you revoke that authorization, unless such authorization was obtained in good faith for published educational media.*
9. ***Required by law****. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect*

or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. ***Public health****. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.*
11. ***Health Oversight Activities****. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.*
12. ***Judicial and Administrative Proceedings****. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.*
13. ***Law Enforcement****. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.*
14. ***Coroners****. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.*
15. ***Organ or Tissue Donation****. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.*
16. ***Public Safety****. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.*
17. ***Proof of Immunization****. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.*
18. ***Specialized Government Functions****. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.*
19. ***Worker's Compensation****. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.*
20. ***Change of Ownership****. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.*
21. ***Breach Notification****. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.*

22. ***Psychotherapy Notes***. *We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceedings, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner upon termination of your life. To the extent you revoke an authorization to use or disclose your psychotherapy notes.*
23. ***Research***. *We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.*
24. ***Fundraising***. *We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.*

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. ***Right to Request Special Privacy Protections***. *You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.*
2. ***Right to Request Confidential Communications***. *You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.*
3. ***Right to Inspect and Copy***. *You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.*
4. ***Right to Amend or Supplement***. *You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.*

5. ***Right to an Accounting of Disclosures***. *You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.*
6. *You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.*

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the way this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

The complaint form may be found at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf.

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ *Date:* _____

Print Name: _____ *Telephone:* _____

If not signed by the patient, please indicate relationship:

- ☐ *Parent or guardian of minor patient*
- ☐ *Guardian or conservator of an incompetent patient*

Name and Address of Patient: _____

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Authorization to Release Medical Information

****** This form must be completely filled out in order to process you request******

*Patient's Name*_____

*Date of Birth*_____ *SSN*_____

I hereby authorize:

_____

Name of Present or Previous physician

_____

Address *City, State, Zip code*

_____

Phone *Fax*

To provide medical information to:

David Alonso MD
564 Rio Lindo Ave, Ste 100
Chico CA, 95926
Fax: **(530) 767-3305**

Date (s) of treatment: _____
Information requested:

_____*All pertinent medical records*
_____*Specific information as indicated:*

For the purpose of:

I authorize the disclosure of my medical records for the purpose stated above. I further understand that I may revoke this authorization at any time, except for actions that has already been taken. This release will be effective for 6 months from the date signed.

_____ _____

Signature (Legal Guardian if applicable) *Date*