Updated as of 2/2024

FAMILY & INDUSTRIAL MEDICAL CENTER

47 Santa Rosa St., San Luis Obispo, CA 93405

Welcome To Our Office!

Patient Information (please print)			
Last Name:	First Name:	Middle Initial:	Sex: M ☐ F ☐
Mailing Address:		City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:	E-mail Address:
Date of Birth: ___/___/_____	Driver's License #:	Social Security Number: ____-___-_____	
Race:	Ethnicity:	Language:	
Marital Status: (Check one):	Married ☐	Single ☐	Divorced ☐ Widowed ☐
Please Let us know if you are interested in having access to our web based patient portal:		YES ☐	NO ☐
Preferred Pharmacy?	**Advanced Directive:** Do you have an Advanced Directive? YES ☐		NO ☐
If patient is a minor, please provide parent/guardian information			
Name of parent/guardian:		Parent/Guardian E-mail:	
Provide address if different than patient:			
Parent/Guardian Date of Birth: __/__/____	Parent/Guardian Social Security Number: ___-__-____		
Emergency Contact Information:			
Emergency Contact Name & Relationship:			
Emergency Contact Phone Number			
Emergency Contact Address:			

Authorization to release protected health information to family and friends

By my signature, I authorize the practice to discuss my appointment dates, time location, medical history, diagnosis, treatment, prognosis, financial and insurance and billing information with those listed below. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.
I understand that except in limited circumstances, a family member or friend seeking information about me must be on the following list.

My personal health information may be released to the following individuals:

1. _____ and/or 2._____

The Practice staff have permission to leave messages concerning my treatment (I.E. Lab results, Radiology results) on my (Please check all boxes that apply)

☐ Home _____ ☐ Cell_____ ☐ Work_____ ☐ E-mail_____

☐ No Information: I do not authorize release of any verbal information (other than appointment reminders to the number(s) I have provided concerning my treatment. I understand that includes lab results and billing information.

_____ _____

Print Name of Patient **Print Name of Authorized Representative**

_____ _____

Patient or Authorized Representative Signature **Date Signed**

Office and Financial Policies

Appointments

If you are more than 10 minutes late to your appointment or reservation, you may be asked to reschedule. Urgent Care and Walk-ins are seen on a first come first serve basis using a light reservation time system, unless considered emergent by way of triage.

Prescription Refills

We require a 72-hour notice for prescription refills. Prescription refills requested Thursday or Friday may not be ready until the following week. In order to expedite this, we ask that you contact your pharmacy and have them contact us instead of calling our office first. Please anticipate your next refill and contact your pharmacy ahead of time.

Lab Results

Please allow up to two weeks for lab test call backs, as deemed appropriate by the provider. All lab results considered essentially normal will not receive a call back.

Our Office Fees are as follows:

$50.00	Appointment No Show Fee (without prior notice)
$25.00	Appointment Cancellation Fee (cancellation within 24 hours of appointment)
$25.00	Prescription Fee (less than 24 hour notice given of refill needed)
$15.00	Prescription Transfer Fee
$25.00	Form Fee (forms up to 4 pages)
$40.00	Form Fee (forms over 4 pages)
$25.00	Letter/Note Fee (work notes, school notes, jury duty letters, etc requested outside an office visit)

Service Charges/Late Fees/Collections/Final Charges and Returns

Any balance carried to the next billing cycle will be subject to a service charge:1% per 30 days beginning on the 60th day. If it is necessary to assign your account to a collection agency and/or attorney, you will be responsible for all FIMC fees/costs associated with that process. **Note that all performed services and dispensed items are non-returnable, and cannot be cancelled upon completion.**

These policies and fees are subject to change at any time. We will do our best to keep you informed of any modifications

Print Name of Patient **Patient or Authorized Representative Signature** **Date Signed**

Acknowledgement of Receipt of Notice of Privacy Policy

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Policies. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Policies.

Print Name of Patient **Patient or Authorized Representative Signature** **Date Signed**

Authorized Representative's authority to act on the Patient's behalf:

☐ Parent/Legal Guardian ☐ Limited Power of Attorney ☐ General Power of Attorney ☐ Other as described_____

Evidence of Authority must be provided and on file with the practice. If you have any questions regarding your privacy as a patient, please contact our administrator at 805-542-9596.

Additional Notices

1. As mandated by the Business and Professions Code, I understand as a consumer that my healthcare provider is licensed and regulated by the Medical Board of California, Physicians Assistant Board of California, or the Board of Registered Nursing of California.
2. In the interest of prompt and efficient patient care, I allow this office to electronically check my external prescription history
3. I hereby authorize the release of any information necessary to file an insurance claim on my behalf with my insurance carrier or any worker's compensation carrier. I assign benefits otherwise payable to me for any service furnished to me. **I understand that I am personally responsible for all insurance negotiated rate balances not paid by my insurance for any reason, and promise to make prompt payment of any outstanding amount**. I also agree to personally pay in full any bill that is unreasonably delayed by litigation.
4. Open Payments Database Notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.
   For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Print Name of Patient **Patient or Authorized Representative Signature** **Date Signed**