PREMIER

WALK-IN MEDICAL

Patient Policy

Welcome to Premier Walk-In Medical
This clinic has the following policies:

1. We require you to provide your photo identification, address, date of birth, current medical insurance card (if you have coverage), social security number and phone number. If you receive health benefits through another family member we required you to provide that person's name, address, and date of birth. Minor's parent/guardian will need to show their identification.
2. To be seen by the doctor you are required to pay for any co-pay, deductible, non-covered service(s) or any outstanding balances prior to being seen. We accept cash and credit cards, no checks. If you are a cash pay patient you are required to pay for the visit prior to being seen.
3. There are charges for each of the medical care services and treatments that we will provide to you. During your visit if you require any additional services and treatments you will be advised of the cost. If you decide to receive these services and treatments you will be required to pay for these in full when you check out with the receptionist.
4. We cannot fill out forms without charging you for their completion and they are a separate fee from an office visit. Form fees will be paid prior to us filling out the form.
   A. Prior Authorization Forms (Per Medication) $30
   B. State Disability Forms $50 up to $100
   C. Employer Disability Forms $50
   D. FMLA Forms $50 up to $200
   E. Medical Records Fees $25 and up
   F. Other Extensive Forms and Paperwork $50 up to $200
5. If you are injured in a motor vehicle accident we will be happy to see you as a patient. However, you will have to pay cash for the visit. Your regular medical insurance usually does not cover this, but your automotive policy does. We will give you a detailed receipt to turn into whichever insurance company you choose.
6. Pharmacies fax us requests for refills of your medications. We do not initiate the process from this office…so please <u>contact your pharmacy</u> for refills before you are seen in the clinic.
7. If you are given medication that might make you drowsy, you MUST have a ride home!
8. We believe time off for workers compensation is over-used and abused. We send you back to work right away, unless you are seriously injured.
9. We do not refill Vicodin or other narcotic prescriptions for chronic pain unless you have been seen by a pain control specialist and they have authorized us to do so.
10. Please do not bring food or drinks into the office or the patient rooms.

This is a very efficient, well-run clinic. All of the people who come here enjoy the way it's managed because it SAVES YOU TIME, and you are treated well by a great staff and great doctors.

Thank you,

H. James Princeton, M.D.

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Medical History Form

Name:	**Date of Birth:**	**Age:**	
Social Security:	**Gender (circle one):**	**Male**	**Female**
Home Phone:	**Cell Phone:**		
Address:	**City:**	**State:**	**Zip**:
Mailing Address If Different:	**Marital Status:** Married Single Divorced Widowed		
Previous Physician Name:	**Your Occupation:**		
Spouse/Parent Name:	**Insurance Subscriber Name:**		
(If Minor, Other Parent's Name):	**Subscriber Relationship to Patient:**		
Emergency Contact Name:	**Date of Birth:**		
Emergency Contact Phone #:	**Social Sec. #:**		
Pharmacy Name/Location:	**Pharmacy Phone #:**		

History:	**(yes)**	**(no)**	**Family History:**	**(yes)**	**(no)**
Alcoholism:	( )	( )	**Alcoholism:**	( )	( )
Anxiety:	( )	( )	**Anxiety:**	( )	( )
Arthritis:	( )	( )	**Arthritis:**	( )	( )
Asthma:	( )	( )	**Asthma:**	( )	( )
Cancer (if yes, type):	( )	( )	**Cancer (if yes, type):**	( )	( )
Depression:	( )	( )	**Depression:**	( )	( )
Diabetes:	( )	( )	**Diabetes:**	( )	( )
Heart Disease:	( )	( )	**Heart Disease:**	( )	( )
High Cholesterol:	( )	( )	**High Cholesterol:**	( )	( )
High Blood Pressure:	( )	( )	**High Blood Pressure:**	( )	( )
Hypothyroid:	( )	( )	**Hypothyroid:**	( )	( )
Kidney Disease:	( )	( )	**Kidney Disease:**	( )	( )
Migraine Headaches:	( )	( )	**Migraine Headaches:**	( )	( )
Seasonal Allergies	( )	( )	**Seasonal Allergies:**	( )	( )
Other Illness:			**Other Illness:**		

Major Surgeries & Dates:	**Social Habits**	**(yes)**	**(no)**
1.	**Alcohol Use:**	( )	( )
2.	**Tobacco Use:**	( )	( )
3.	Packs Per Day:		

Current Medications:	**Medication Allergies:**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Women Only

Date of last Pap, Mammo & Results:

Pregnancies: **Births:** **Miscarriages:**

What are you currently using for Birth Control?

Signature: **Date:**

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ACKNOWLEDGEMENT OF INFORMATION FORM

Notice of Privacy Practices

I hereby acknowledge that I received a copy of the Notice of Privacy Practices from Premier Walk-In Medical, Inc. I further acknowledge that a copy of the current notice will be available at each appointment.

Notice of Medical Board Information to Consumers

Medical doctors are licensed and regulated by the Medical Board of California.
The Medical Board may be contacted by phone (800) 633-2322 or website www.mbc.ca.gov

Physician Assistants are licensed and regulated by the Physician Assistant Committee.
The Physician Assistant Committee may be contacted by phone (916) 561-8780 or website www.pac.ca.gov

Consent to Photograph

Authorization is given to Premier Walk-In Medical, Inc. to take my photograph for the sole purpose of patient identification.

If not signed by the patient, please circle relationship to patient. Parent or Guardian of minor patient.

Print Name: **Date:**

Signature:

PREMIER
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Financial Policy

Insurance: We participate with many insurance plans. Your insurance company provides you with proof of insurance, which must be presented at time of service. If you do not have proof of insurance you will be considered a private pay patient. If your insurance changes please notify the receptionist when checking in. We bill your insurance directly as a courtesy. Your individual insurance plan is an agreement between you and your insurance company. It is necessary for you to know the specific details of your own plan. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Pays, Deductibles and Non-Covered Services: If your plan has co-pays, deductibles and non-covered services it is your responsibility to pay those at the time of service. This arrangement is part of your contract with your insurance company. These will be collected when you check in with the receptionist. Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full.

Private Pay: If you do not have health insurance or have coverage with a plan with which we do not participate it is our policy that you must pay at the time of service. This will be collected when you check in with the receptionist.

Methods of Payment: For your convenience we accept cash and most credit/debt cards.

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Responsible Financial Party Information

Name: _____

Date of Birth: _____

Social Security: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Authorized Signature: _____ **Today's Date:** _____