GASLAMP

MEDICAL CENTER

250 Market Street, San Diego, Ca. 92101

REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Blue Cross	❑ PacifiCare	❑ Secure Horizon	❑ Health Net	❑ Blue Shield
❑ Cigna	❑ United HealthCare	❑ Aetna	❑ Medicare ❑ Medical	❑ Scan	❑Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Gaslamp Medical Center or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

GASLAMP
MEDICAL CENTER
(619) 239-9675 ● (619) 515-1136 Fax

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my protected health information by **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.**

I understand that diagnosis or treatment of me by **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** may be continued upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** is not required to agree to the restrictions that I may request, however, if **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** agrees to a restriction that I request, the restriction is binding on **GASLAMP MEDICAL CENTER and ALFREDO QUINONEZ M.D.**

I have the right to revoke this consent, in writing at any time, except to the extent that **GASLAMP MEDICAL CENTER, or ALFREDO QUINONEZ M.D.,** has taken action in reliance on this consent.

My "protected heath information" means health information, including my demographic information, collected from me and created or revived by physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.'s** Notice of Privacy Practices prior to signing this document.

The **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.'s** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.**

The Notice of Privacy Practices for **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** is also provided in the reception area.

The notice of Privacy Practices also describes my rights and duties of ALFREDO QUINONEZ M.D., with respect to my protected health information.

GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be mailed or by asking for one at the time of my next appointment.

_______________________________ _______________________________
Signature of Patient or Personal Representative — Date

_______________________________ _______________________________
Name of Patient or Personal Representative — Description of Personal Representative's Authority

DISCLAIMER: This document and the information in it do not constitute legal advice. It is also not a substitute for legal or professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

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CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.,** to use and disclose my medical information for the purposes of **TREATMEANT**, **PAYMENT**, and **HEALTH CARE OPERATIONS**.*

> ***TREATMENT** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physicians.
>
> ***PAYMENT** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities, which may include review of health, care services for medical necessity, justification of charges, pre-certification and pre-authorization.
>
> ***HEALTH CARE OPERATIONS** includes the necessary administrative and business functions of our office.

I further authorize **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** to use and disclose the following specific health and medical information for the below listed purpose(s):

> Specific medical information consisting of:
>
> For the specific purpose of:

*I understand that I have the right to revoke this Consent provided that I do so IN WRITING except to the extent that **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** has already used or disclosed the information in reliance on this consent.*

____________________________________ ______________________
Signature of Patient   Date

____
Signature of Person Authorized by Law

(See reverse side)

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GASLAMP
MEDICAL CENTER

If the **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ M.D.** is requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We can not condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provide that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review **GASLAMP MEDICAL CENTER, ALFREDO QUINONEZ, M.D.'s** "Notice of Privacy Practices" for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent. Please verify that you have received a copy of our Notice by placing your initials here: __________.

Because we have reserved the right to change our privacy practices in accordance with the law, the term contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effect date of the Notice in the upper right hand corner. We will offer you a copy of the Notice on your first visit to us after the effective date of the then current Notice. We will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.