PATIENT DEMOGRAPHICS FORM

INFORMATION PATIENT

Patient's Last Name:	First:	Middle:
Street Address:		
City, State, Zip:		
Home Phone: May we leave a voicemail message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended	Cell Phone: May we leave a voicemail message? ❑ Yes ❑ No May we leave a text message? ❑ Yes ❑ No If yes, select type of message: ❑ Brief ❑ Extended	
Date of Birth:	Gender: ❑ Male ❑ Female	
Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated		SSN:
Email Address:	Preferred Language: ❑ English ❑Spanish ❑ Other	
Who is your family doctor?	Who referred you to Dr. Cluck?	
Race: (Select one) ❑American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other Race		Ethnicity: (Select one) ❑ Hispanic or Latino ❑ Not Hispanic or Latino

INSURANCE INFORMATION

Person Responsible for Bill:	Birth Date:	Home Phone:
Address (if different):		
Primary Insurance Name:		
Subscriber's Name:	Policy #:	
Subscriber DOB: Subscriber SSN:	Group #:	
Patient's Relationship to Subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other		
Secondary Insurance Name:		
Subscriber's Name:	Policy #:	
Subscriber DOB: Subscriber SSN:	Group #:	
Patient's relationship to subscriber: ❑ Self ❑Child ❑ Spouse ❑ Other		

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Contact Number:

PREFERRED PHARMACY

Name: Location:	Phone:	Fax:

Valley Spine Care - Michael W. Cluck, MD, PhD
1170 W. Olive Ave Suite B, Merced CA 95348
Phone: 209-276-2200 | Fax: 209-276-2202

PATIENT ACKNOWLEDGMENT

By signing this document below, the patient or responsible party acknowledges they have read and understand the following:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician to release any record, x-rays, and photographs acquired in the course of my treatment to referring physicians, insurance companies, hospitals or surgery centers. I authorize the release of all information necessary to transmit and process claims electronically and/or through any other reasonable and customary means in order to secure payment.

PHYSICIAN ASSISTANTS

Valley Spine Care utilizes Physician Assistants in our office. Physician Assistants may provide care for you during your office visit. By signing this form, you give permission to have Physician Assistants assist in your care.

MEDICAL STUDENTS/INTERNS

Dr. Michael W. Cluck is a professor/faculty for medical students, interns, fellowship and residents. You agree to permit the students/residents working in your physician's office to observe and participate in your medical care during your care with Valley Spine Care. Your physician has agreed to permit such students to observe and participate in his/her patient care activities, including, where appropriate, providing medical care to patients under the physician's direct supervision and observe during surgery.

CONSENT TO TREAT

I hereby volunteer consent to my treatment at Valley Spine Care and authorize such treatments, examinations, physical therapy and diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered by my attending /covering physician.

E-PRESCRIBING

Valley Spine Care providers utilize e-Prescribing to electronically send an accurate, error free and understandable prescription directly to a pharmacy. By signing below, you are providing your consent for the pharmacy e-Prescription program.

_____ _____

Signature of Patient/Legal Guardian Date

Valley Spine Care - Michael W. Cluck, MD, PhD
1170 W. Olive Ave Suite B, Merced CA 95348
Phone: 209-276-2200 | Fax: 209-276-2202

RECEIPT OF NOTICE OF PRIVACY PRACTICES & RELEASE AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164)

Patient Name_____**DOB:** _____

I authorize Valley Spine Care to use and/or disclose the Protected Health Information (‘‘PHI’’ or personal medical records) described below to: **(Note: this includes releasing prescriptions, medical forms, etc.)**

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name _____ Relationship _____ Phone _____

I hereby authorize the release of my personal medical information as follows:

(Select One)

☐ a. My complete health record “PHI” (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

☐ *b.* My complete health record “PHI” *with the exception of the following information* **(circle as appropriate):**

Mental health records — Communicable diseases (including HIV and AIDS)
Alcohol/drug abuse treatment — Other (please specify): _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation,

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient/Legal Guardian Date

Valley Spine Care Financial Policy

PATIENTS WITH INSURANCE: Although we bill your insurance company/medical group for services rendered, you are financially responsible for all services rendered. If payment has not been received within sixty (60) days of billing your health plan/medical group, we may contact you for assistance. If your health plan/medical group denies coverage for any reason, you will be responsible for that payment.

PATIENTS WITHOUT INSURANCE: Our fees cannot always be determined in advance, since they depend on actual services provided. If you would like an estimated total amount before being seen, please ask the front desk personnel. Please note that this is only an estimated amount and the actual charge totals may vary from this estimate. Payment for all services is due at the time of service.

CO-PAY POLICY: It is your obligation to be familiar with our insurance co-payment and/or deductible amounts. *Your co-pay amount must be paid at the time of your visit or we will have to reschedule your appointment*.

DELINQUENT ACCOUNTS: Interest of 2% will be applied every month for any past due accounts.

RETURNED CHECKS: There will be a $25.00 service fee for returned checks.

CANCELLATION AND "NO SHOW" ADMINISTRATIVE FEE POLICY:
Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Effective January 1, 2020, Valley Spine Care reserves the right to charge a fee for missed appointments ("no shows") and appointments not canceled with a 24-hour advance notice. The following fees will be assessed for no-shows and late cancellations:

"No Show" $150
Less than 24 hours notice: $100

Late cancellation fees will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" and late cancellations in any 12-month period will result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients. By signing below, you acknowledge that you have received this notice and understand this policy

_____ _____

Patient Name Date

Valley Spine Care
Michael Cluck, MD, PhD, FAAOS

1170 W. Olive Ave, Suite B
Merced, CA 95348
209-276-2200 Phone | 209-276-2202 Fax
ValleySpineCare.com

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

1/6/2022

This Notice of Privacy Practices applies to the following organizations.

Valley Spine Care

Questions or concerns? Contact: Tania Hyatt, Director of Operations
209.276.2200 ext 1003 Phone
tania@valleyspinecare.com