Robert Houghton, M.D.
1855 First Ave. Suite 200B
San Diego, CA 92101

PATIENT INFORMATION

TODAY'S DATE	ARE YOU A NEW PATIENT?	FOR PROVIDER USE ONLY: CHECKOFF LIST **DX:**_______________________________ ☐ Card Copies (front and back) Attached ☐ Insurance Verification Form Attached ☐ Authorization Attached if Applicable
FIRST NAME MIDDLE NAME	LAST NAME	

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

EMAIL ADDRESS	DATE OF BIRTH	AGE	GENDER ☐ MALE ☐ FEMALE

ETHNICITY (OPTIONAL)	SOCIAL SECURITY NO.	DRIVER'S LICENSE NO.	MARITAL STATUS ☐ SINGLE ☐ MARRIED	☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

EMPLOYMENT STATUS ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED	☐ NONE ☐ SELF-EMPLOYED ☐ ACTIVE MILITARY	STUDENT STATUS ☐ FULL TIME ☐ PART TIME ☐ NONE

RESPONSIBLE PARTY INFORMATION

(Complete this section ONLY if different from above)

FIRST NAME	MIDDLE NAME	LAST NAME

BILLING ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

RELATIONSHIP OF PATIENT TO RESPONSIBLE PARTY ☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY)	SOCIAL SECURITY NO.	DRIVER'S LICENSE NO.

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT PERSON		RELATIONSHIP TO PATIENT
HOME PHONE	WORKPHONE	MOBILE PHONE

HOW DID YOU HEAR ABOUT US?

☐ DOCTOR REFERRAL ☐ FRIEND OR RELATIVE	☐ INSURANCE COMPANY ☐ INTERNET OR WEBSITE	☐ MAGAZINE OR NEWS ARTICLE ☐ TELEVISION	☐ GSDBA ☐ OTHER _____________ ______

INSURANCE INFORMATION

(Please provide copies of ALL ID cards, front and pack, if applicable)

☐ Please Check Here If You Have No Insurance And You Will Be Solely Responsible For Payment (Skip to Consent to Disclose Account Information)

PRIMARY INSURANCE NAME			SECONDARY INSURANCE NAME		
INSURANCE PHONE NUMBER	EFFECTIVE DATE		INSURANCE PHONE NUMBER	EFFECTIVE DATE	
CLAIMS ADDRESS			CLAIMS ADDRESS		
CITY STATE ZIP			CITY STATE ZIP		
SUBSRIBERS NAME	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	SUBSCRIBERS NAME	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH
SUBSCRIBERS ID	GROUP NO.		SUBSCRIBER ID	GROUP NO.	
SUBSCRIBERS EMPLOYER	DEDUCTIBLE $	COPAYMENT $	SUBSCRIBERS EMPLOYER	DEDUCTIBLE $	COPAYMENT $
RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY) _______________			RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER (SPECIFY) _________________		

FOR WORKERS COMPENSATION INSURANCE ONLY:

DATE OF INJURY: STATE IN WHICH INJURED:

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN NAME	PHONE NO.
PRIMARY CARE PHYSICIAN ADDRESS (IF KNOWN) CITY STATE ZIP	

MAY WE CONTACT YOUR PHYSICIAN SO THAT THIS PROVIDER MAY BE FULLY INFORMED AND SO THAT WE MAY COORDINATE YOUR TREATMENT?

☐ YES
☐ NO

CONSENT TO DISCLOSE ACCOUNT INFORMATION

According to State and Federal confidentiality laws, we cannot disclose any information about you to any other person without your consent. This includes other family members, unless you are less than 18 years old, or under certain legal circumstances.

I understand that “information” includes activities involved in determining my eligibility for health plan coverage, billing and receiving payment from me and my health insurance plan, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pro-certification and pre-authorization.

I authorize this medical provider to disclose details of my account and my care to the following person(s) to ensure that payment is received for the services rendered to me.

☐ PLEASE CHECK HERE IF YOU DO NOT WISH ANYONE ELSE TO HAVE ACCESS TO YOUR FINANCIAL INFORMATION.

FIRST NAME MIDDLE NAME LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
FIRST NAME MIDDLE NAME LAST NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

POLICY STATEMENT

Thank you for choosing our office for your medical needs. We are committed to providing the best possible treatment. Please understand that payment for services is considered part of your treatment. The following sets forth the terms and conditions upon which our services are rendered:

CONSENT OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: You hereby consent to the use or disclose of your protected health information by Robert Houghton, MD for the purpose of diagnosing, or otherwise providing treatment, obtaining payment for your healthcare services or to conduct healthcare operations. **You understand that receiving diagnosis or treatment is conditioned upon your consent as evidenced by your signature on this document.**

You understand you have the right to request a restriction as to how your protected health information is used or disclosed, to carry out treatment, payment, or healthcare operations of this medical practice.

Robert Houghton, MD is not required to agree to the restrictions that you may request, however, if this office agrees to any restriction, then the restriction is binding. You have the right to revoke this consent, in writing, at any time, except to the extent that Robert Houghton, MD has taken action in reliance on this consent.

Your “protected health information” means health information, including demographic information, collected from you, and created or received by this provider, another health care provider, a health plan, my employer or a healthcare clearing house.

You understand that this medical office reserves the right to change the privacy practices that are in the Notice of Privacy Practices. You may obtain a revised notice of our privacy practices by requesting it in writing, either by mail or at your next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient except as noted above. However, there are some instances where reporting rules are mandated by law.
These include, but are not limited to, abuse of minors, or if you express the intent of bringing harm to yourself or someone else. In such circumstances, the provider is required to inform potential victim(s) and/or legal authorities.

PAYMENT OF FEES: Payment for services is the patient’s responsibility (or parent/guardian, if patient is a minor). I agree to pay my share of the charges, such as copayment and deductible amounts at the time of each visit. The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. I understand that Robert Houghton, MD’s fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. Please note that this office charges a $25 service fee for all returned checks.

COLLECTION NOTICE: If payment is not made at the time the monthly billing statement is received, you may be responsible for interest and penalties. Dr Houghton subscribes to a collection policy for any unpaid debt. Once your bill goes into collections you will be responsible for all attorney fees, interest and penalties. If your account is sent to collection you will be discharged from the practice.

INSURANCE: This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and your insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company. We may be required billing your medical group or a third party payer. It is the responsibility of the patient to know if this is the case.

PRIOR AUTHORIZATION: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is the case for your insurance coverage(s), and to get the necessary authorization(s) before your appointment.

APPOINTMENTS: Your appointment time has been reserved exclusively for you. You agree that if you fail to cancel an appointment with at least 24 hours’ notice, you may be billed a fee of $40.00 at the discretion of Robert Houghton, MD.

You understand that insurance companies do not pay for missed appointments.

MEDICAL RECORDS: You understand that Robert Houghton, MD will retain your medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to the authorized party.

MEDICATIONS: You understand that medication refills will be considered during normal office hours only. This is so that we may comply with California Pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of Robert Houghton, MD or otherwise obtaining medication illegally. You further understand that if you should need to have a prescription refilled that you should contact your pharmacy at least 1-2 days prior needing the medication or the medication may not be available to you the same day. You understand refills for any medication will not be granted unless you have been seen within the last six months.

AGREEMENTS: You have reviewed the preceding information and certify that this information is accurate. You further understand that you are responsible for any financial loss due to incomplete or inaccurate information provided on this form.

You hereby authorize payment directly to this medical provider, any insurance benefits that would otherwise be payable to you for services rendered.

In instances where insurance does not pay any benefits, you agree to pay for those services. If payment is not received within 90 days from the date the claim was submitted, you agree to become responsible for the full amount of the balance on your account.

Should you break any financial arrangements detailed above, you agree that your name may be released for collection purposes. You understand that no treatment related information will accompany this disclosure. You also agree that if any legal action is taken to enforce the provisions of this Policy Statement that the prevailing party shall be entitled reasonable attorney's fees and cost recovery.

I have read this Policy Statement and agree to the terms as written.

________________________________ ___________

PATIENTS NAME (Please Print) Initial here if you would like a copy

____________________________________ ____________________

RESPONSIBLE PARTY (Signature) Date

To Our Valued Patients:

We are pleased and excited to have a branch of Quest Diagnostics on-site. It is a valuable service for our patients to have their labs done during the same visit. Quest is very supportive, and will assist you even if your insurance is contracted through a different lab company.

We would like to inform you, however, that while Quest Diagnostics maintains a lab on-site, they are a separate business entity. As such they may ask you for your demographics and insurance card again. Also, please be aware that while Quest will make an effort to accommodate you without an appointment, they are sometimes busy and there may be a wait to receive services.

If you are interested in faster, more convenient services with Quest, and you anticipate lab requirements coinciding with your Doctor's visit, you may schedule an appointment on their website for a convenient time:

http://www.questdiagnostics.com/home/patients.html

Please be aware that if your doctor orders labs, it is important for you to be aware of your insurance and any limitations. Quest Diagnostics can give you a price estimate on your labs if you are contracted through them. We also work with LabCorp, Sharp, and other providers.

If you are not covered through your insurance or are able to pay the lab charges from Quest, please inform your Doctor during your visit.

______________________________ ________________

Signature Date

APPOINTMENT CANCELLATION POLICY

Missed Appointments Cost Money!

Please be aware than an appointment not cancelled at least 24 hours in advance may result in a $40 no-show fee, billed directly to you. To avoid this, please contact our office immediately if you are unable to make your appointment.

Please acknowledge this policy by signing in the space provided below.

____________________________ ______________

Signature Date

RELEASE OF INFORMATION

I, _________________________________, **Social Security #:___________________ Expires: __________________**

Date of birth:___________________

hereby authorize: Robert Houghton, M.D. (1855 FIRST AVE SUITE 200B SAN DIEGO, CA 92101)

to release to: ____

By signing below, I hereby authorize Dr. Robert Houghton, M.D or agent, to obtain information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities.

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment. **The following information is requested: (patient* or legal guardian √ items to be released).**

__Psychiatric Evaluation
_x_ History & Physical
_x_ Practitioner Orders
_x_ Practitioner Progress
__Discharge Summary

_x_ Laboratory Reports
_x_ Immunization Records
_x_ Medication Records
_x_ Treatment/Individualized Service Plan
__Discharge Instructions

__x_ Financial Account information
___Other (specify)________________
____
____

The Purpose or Need for Disclosure is:

__To Transfer Client Care
_x_ For Follow Up Care
__To Inform Family
_x_ Referral Source
__Legal/Court System

_x_ To Aid in Treatment
__For Discharge Planning
_x_ To Update Medical Records
__Employer

__Application for Provider Coverage
__Psychological Report
_x_ To Aid in financial account activity
__Other (specify) ______________
____

I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected by federal and state privacy laws and regulations.
I understand that **Robert Houghton, M.D.** will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

____ __________________________________
Patient or Authorized Representative Signature Date

____
Print Name Relationship to Patient (if applicable).

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.