

# Lincoln Internal Medicine

## Patient Information

Male       Female

Doctor: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Patient's Email Address: \_\_\_\_\_

Marital Status:  S    M    W    Div    Sep      Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Spouse's Home Address:  
(if divorced or separated): \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

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Person to notify in case of emergency (note: person should not live at same residence):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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## Insurance Information (indicate which insurance is primary [1] and which is secondary [2] in boxes below)

Name of Insurance: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber:  Self    Spouse    Other: \_\_\_\_\_

Primary    Secondary

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Name of Insurance: \_\_\_\_\_

Insurance ID # \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber:  Self    Spouse    Other: \_\_\_\_\_

Primary    Secondary

Please complete this section if patient is a minor.

Student:  Full Time  Part Time

Responsible Party's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

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**Authorization for assignment of benefits and information release**

I, the undersigned, authorize payment of medical benefits to Lincoln Internal Medicine for any services furnished to me by the physicians. I understand I am financially responsible for any services not covered by my insurance. I further agree to pay reasonable attorney fees and court costs in the event that legal action becomes necessary to enforce this contract. I also authorize you to release my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

**\*\* Upon receipt of the necessary information, we will bill any preferred plans in which we participate. We will also bill private insurance companies for certain procedures as a courtesy to assist you with your reimbursement. Payment is expected within thirty days. If payment is not received within this time period, any charges will become your immediate responsibility.**

How did you hear about our practice? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

<b>SYMPTOMS</b> Check (✓) symptoms you currently have or have had in the past year.			
<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

<b>CONDITIONS</b> Check (✓) conditions you have or have had in the past.			
<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease

<b>MEDICATIONS</b> List medications you are currently taking	<b>ALLERGIES</b> To medications or substances
Pharmacy Name _____ Phone _____	



**Lincoln Internal Medicine**  
**801 Sterling Parkway, Suite 120**  
**Lincoln CA 95648**

Tel: (916) 408-3773

Fax: (916) 408-3853

[www.lincolnimed.com](http://www.lincolnimed.com)

## **PRIVACY POLICY**

Our practice policy is that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) of our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and protected health information to provide the highest quality medical care possible while protecting the protected health information and confidentiality of our patients.

Our practice and its physicians and staff will not use or disclose PHI for uses outside of treatment, payment or healthcare operations (TPO) without an authorization from the patient.

Our practice will use and disclose PHI to remind patients of their appointments within the minimum necessary standard.

We recognize that patients have a right to privacy. Our practice and its physicians and staff respect the dignity of the patient at all times and treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete.

We may permit access to medical records with a written request. The request must be approved by our practice. If we deny the request, then we must inform the patient that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the appeal.

We will provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

Our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

Our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

All physicians and staff will adhere to this policy. Violations of this policy will not be tolerated by our practice and is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions.

We may change this privacy policy at any time. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

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**PATIENT RIGHTS**

Lincoln Internal Medicine has adopted the following written policies concerning the rights and responsibilities of all patients.

**PATIENTS HAVE THE RIGHT:**

1. To considerate and respectful care; cultural, psychosocial, spiritual, personal values and beliefs will be respected. Patients with vision, speech, hearing, language and cognitive impairments have the right to effective communication.
2. To every consideration of his/her privacy concerning his/her medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential. Those not directly involved in his/her care must have permission of the patient to be present. Disclosure of records is treated confidentially and except when required by law, patients are given the opportunity to approve or refuse their release.
3. To receive, to the degree known, complete information concerning their diagnosis, evaluation, treatment and prognosis.
4. To participate in discussions involving their health care.
5. To be informed of patient rights, Lincoln Internal Medicine's expectation of patient conduct and responsibilities, services available, provisions for after hours care, fees and payment policies.
6. To express suggestions to Lincoln Internal Medicine, to voice complaints, and have those complaints impartially investigated with a response in no more than seven business days. Complaints should be directed to the Office Manager.

**PATIENT RESPONSIBILITIES**

1. Bring your insurance card to each visit --notify receptionist if there are changes to home address, phone number or insurance.
2. All co-payments, deductibles and other patient portion due for non-covered benefits will be collected at the time of service.
3. We require at least 48 hours notice for an appointment cancellation.
  - a. A patient will be discharged from the practice if proper notice is not given for cancellation of an appointment.
4. All visits (Coumadin Clinic, BP check, injections) to Lincoln Internal Medicine require an appointment.
5. Be respectful of other patients' privacy while checking in.
6. To refill a prescription that was prescribed to you by Lincoln Internal Medicine, please call your pharmacy. They will in turn call/fax our office to complete the refill process.
  - a. Please allow 2-3 business days for prescription refills
  - b. If you need a refill on a prescription that was issued by another physician, an appointment may be necessary.
7. All referrals, once issued to you by our doctor take 2-3 business days to process.
  - a. Authorizations for services may take an additional 3 business days to process.
8. Please allow 5 business days for results to be received and interpreted by your physician.
9. You may obtain a copy of your medical record upon written request.
  - a. The charge for reproducing your medical record is .25 per page, clerical fees and postage.
10. There is a fee of \$20 to the patient for completion of disability, DMV, EDD, etc. forms. This must be paid prior to the form being filled out.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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**Acknowledgement of Receipt of Practice Privacy Policy and Authorization for  
Use or Disclosure of Protected Health Information**

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\_\_\_\_\_ Please initial here to acknowledge that you have received a copy of Lincoln Internal Medicine's Privacy Policy.

I authorize my physician and/or administrative and clinical staff to disclose information regarding my care and treatment at Lincoln Internal Medicine to:

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This authorization shall be in force and effect until I inform Lincoln Internal Medicine that I wish to revoke the authorization. I understand that I may revoke this authorization by writing to the Privacy Officer at 801 Sterling Parkway, Suite 120, Lincoln CA 95648. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information 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 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.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except when health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

This form does not constitute legal advice and is for educational purposes only. This form is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance. This form is based on federal law and must be modified to reflect state law where that state law is more stringent than the federal law or other state law exceptions apply.

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**801 STERLING PARKWAY, SUITE 120**  
**LINCOLN CA 95648**  
**(916) 408-3773 FAX (916) 408-3853**

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize: \_\_\_\_\_  
(name of person and or facility which has information)

\_\_\_\_\_  
(Street address, City, State and Zip Code)  
to release health information to: LINCOLN INTERNAL MEDICINE  
801 STERLING PARKWAY, SUITE 120  
LINCOLN CALIFORNIA 95648

Please specify the type of health information that you authorize to be released:  
 MEDICAL                       MENTAL HEALTH (other than psychotherapy notes)

Type(s) of health information: \_\_\_\_\_

Date(s) of treatment: \_\_\_\_\_

The following information will not be released unless you specifically authorize it:

- I specifically authorize release of information pertaining to drug and alcohol abuse diagnosis or treatment (C.F.R. §2.34 and §2.35)
- I specifically authorize the release of HIV/AIDS test results (Health and Safety Code § 120980 (g).
- I specifically authorize the release of genetic testing information (Health and Safety Code §124980(j)).

The purpose of this release is:

- At the request of the patient/patient representative
- Other (state reason): \_\_\_\_\_

**Notice:**

LIM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**Your Rights:**

This authorization to release health information is voluntary. Treatment, payment, enrollment of eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine the entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by your or your representative and delivered to April Hillard, Health Information Manager at Lincoln Internal Medicine. The revocation will take effect when LIM receives it, except to the extent that LIM or others have already relied on it.

You are entitled to receive a copy of this authorization

**Expiration of Authorization:**

Unless otherwise revoked, this authorization expires on \_\_\_\_\_ (insert applicable date or event).  
If no date is indicated, the authorization will expire in 12 months from the date of my signing.

Print Name	Signature (Patient, Parent, Guardian)
Date	Relationship to Patient (i.e. Parent Guardian, Conservator, Patient Representative)
Time	Witness (only if patient is unable to sign) Interpreter