Tremayne Center for Medicine
1600 Sunrise Ave, Ste 16, Modesto, CA 95350
Phone 209-549-1600 • Fax 209-549-1601
www.tremaynemedicine.com

Hello and welcome.

Thank you for choosing Tremayne Center for Medicine as your primary health-care provider. We look forward to partnering with you, as your personal team of medical providers, to assist you with you ongoing medical care

We strongly believe in a philosophy of being well and living healthy. We recognize that practicing medicine requires a partnership between the patient and the doctor's office. And Dr. Tremayne believes strongly that the best treatment for patients utilizes a comprehensive approach that minimizes potentially harmful procedures, medications, and even surgeries. Our team of providers includes: nurse practitioner-dietician, chiropractic, physical therapy, neuro-reflexology, Tui-Na massage therapy and even a Yoga instructor.

As an Osteopathic Physician, Dr. Tremayne is trained to treat you – the whole person – not just a disease or its symptoms. She believes your body when properly treated and maintained, is capable of self regulation, self maintenance and even self healing. And she enlists her team of providers as needed to help you body heal and build and maintain a better lifestyle.

Thank you for choosing the Tremayne Center for Medicine, your complete health care resource, for your health care needs. .

We look forward to seeing you soon!

Dr. Paula Tremayne and Staff

209.549.1600

Patient name: _____

Date of birth: ___/___/_____

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SERVICE PROMISES:

We always want your experience to be a positive one and offer the following service promises. This is what you can expect from our staff and what we expect from our patients.

Timeliness: We realize that your time is valuable and we strive to stay on schedule. That is why we ask that you arrive a few minutes prior to your scheduled appointment time so that you can be checked in. Please understand that occasionally an emergency may arise that may need immediate attention and may cause extra wait time. Also, we ask that you respect fellow patients by keeping to your appointment time.

Medical issue: Please let our Medical Assistant know what issues are most important to you so that Dr. Tremayne's team of medical providers can address those issues, quickly and efficiently.

Medication list: Please bring all of your prescriptions, over-the-counter medications, and herbal products to your appointment. Bringing the actual bottles will ensure an accurate medication list.

Lab Results: We ask the laboratories to send a copy of your lab results directly to you for your records. If there are concerns with your lab results we will call you to schedule an immediate appointment, otherwise the results will be discussed at your next visit. If you would like to speak with Dr. Tremayne about your results we will gladly schedule an appointment.

Referrals: We usually complete urgent referrals within 24 hours, depending on patient condition. Non-urgent referrals may take up to 1-2 weeks depending on where you may be referred to. Occasionally, referrals need to be preauthorized by your insurance company which requires additional time to process. Once completed, we'll call you with an appointment time. If you need to reschedule you may follow up directly with the specialist. If you haven't hear from us within 2 weeks, please call us to receive a status update.

Prescriptions are electronically sent or faxed to your preferred pharmacy during your office visit. Please understand that it can take two or more hours for your pharmacist to process your prescription. Dr. Tremayne will prescribe enough refills to last until your next scheduled visit. In the event you need a prescription refill, please have your pharmacist electronically send or fax your refill request to **209-549-1601**. Please allow two to three days for refills to be processed. No request for refills can be processed after 4:00 p.m. Dr Tremayne **does not** provide early refills for scheduled medications, i.e. pain medication. If you need a new medication or a change to your existing medications please schedule an office visit.

Phone communications: If you have questions, please feel free to call us at your convenience. We strive to answer all calls with a dedicated staff member. In the event the office is busy, you may leave a voice message which will be returned as soon as we can. Please speak clearly, provide a correct phone number and the reason for your call.

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NEW PATIENT DEMOGRAPHIC SHEET:

DEMOGRAPHICS

Who referred you? _____ Today's Date: _____/_____/_____

Name: _____ Spouse Name:_____
LAST FIRST MIDDLE OR PARENT'S IF MINOR

Gender: M / F Social Security Number: _____-___-_____ Date of Birth: ___/___/____ Age: _____

Marital Status: Single Married Widowed Divorced Minor

Address: _____
STREET CITY STATE ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email address: _____

Preferred contact/reminder method: phone / home phone / cell phone / text / email / U.S. mail

What is your occupation and employer? _____

PHARMACY

Local Pharmacy: _____ Location: _____ Mail order Pharmacy: _____

EMERGENCY NOTIFICATION

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ ID#: _____ Group #: _____

Name of policy holder: _____ SS#:____-____-_____ Date of Birth: ___/___/_____

Secondary Insurance Company: _____ ID#: _____ Group #: _____

Name of policy holder: _____ SS#:____-____-_____ Date of Birth: ___/___/_____

RACE - ETHNICITY

PLEASE SELECT THE APPROPRIATE RACE-ETHNICITY

- ☐ Decline
- ☐ American Indian or Alaskan
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____

Primary language spoken in your home: _____

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Date of birth: ___/___/_____

NEW PATIENT PERSONAL MEDICAL HISTORY:

REVIEW OF SYMPTOMS Check ☑ if you have recently experienced any of the following symptoms

GENERAL: ☐ feeling well ☐ chills ☐ fatigue ☐ fever ☐ weight gain ☐ weight loss ☐ night sweats

EYES: ☐ blurred vision ☐ glasses/contact lenses

E/N/T: ☐ hearing loss ☐ ringing ☐ nasal congestions ☐ sore throat

CARDIOLOGY: ☐ chest pain ☐ dizziness ☐ palpitations ☐ rapid heart beat

RESPIRATORY: ☐ cough ☐ shortness of breath ☐ wheezing

STOMACH: ☐ abdominal pain ☐ constipation ☐ diarrhea ☐ heartburn ☐ nausea ☐ vomiting

MALE/FEMALE GENITAL: ☐ painful urination ☐ blood in urine ☐ frequent urination ☐ urinary incontinence ☐ frequent UTI's ☐ irregular menstrual cycle ☐ vaginal discharge ☐ vaginal itching

MUSCULOSKELETAL: ☐ arthritis ☐ back pain ☐ muscle pain

SKIN: ☐ atypical mole ☐ wart ☐ rash

NEUROLOGICAL: ☐ dizziness ☐ headaches ☐ memory loss

HEMOTOLOGIC/LYMPHATIC: ☐ easy bruising ☐ excessive bleeding ☐ enlarged lymph nodes

ENDOCRINE: ☐ temperature intolerances ☐ hair loss ☐ hot flashes ☐ sexual dysfunction

ALLERGIC/IMMUNOLOGIC: ☐ seasonal allergies

PSYCHIATRIC: ☐ anxiety ☐ Low energy ☐ sleep disturbances

Other: _____

CURRENT MEDICATIONS: OR ATTACH LIST	**ALLERGIES:**

PAST MEDICAL HISTORY: Check ☑ if applicable				**PAST SURGICAL HISTORY:** year of surgery
☐ Anemia	☐ Asthma/COPD	☐ Cancer	☐ Diabetes	
☐ Heart Disease	☐ High Cholesterol	☐ Hypertension		
☐ Kidney issues	☐ Thyroid disease	☐ Stroke		

FAMILY HISTORY: Check ☑ if applicable			**SOCIAL HISTORY:**		
☐ Asthma	☐ Cancer	☐ Diabetes	use tobacco? ☐ Yes ☐ No	If yes, how often? _____
☐ Gout	☐ Diabetes	☐ Hypertension	drink alcohol? ☐ Yes ☐ No	If yes, how often? _____
☐ Heart Attack/Disease	☐ High cholesterol		recreational drugs? ☐ Yes ☐ No	If yes, how often?_____
☐ Stroke	☐ Thyroid disease		exercise regularly? ☐ Yes ☐ No	If yes, how often?_____

WOMEN & MEN: Check ☑ if applicable	**IMMUNIZATIONS:**
Women: mammogram? ☐ Yes ☐ No If yes, when?_____ DEXA ☐ Yes ☐ No	Influenza: _____
Date of last vaginal PAP? _____ History of abnormal PAP ☐ Yes ☐ No	Pneumovax: _____
Men: Have you had a prostate exam? ☐ Yes ☐ No If yes, when?_____	Tetanus: _____
Do you have pain/other issues with your penis or testicles? _____	Varucella/Shingles: _____

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NOTICE OF PRIVACY PRACTICES:

HIPPA CONSENT:

Our Legal Duty

We are required by applicable federal and state law, including the Health Insurance Portability & Accountability Act of 1996 (HIPPA), to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. This Notice takes effect 1/1/2011 and will remain in effect until we replace it.

You may request a copy of our notice at any time of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes.

We may use and disclose medical information about you for the following purposes:

- Treatment: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.
- Payment: We may use and disclose your medical information to obtain payment for services we provide you.
- Health Care Operations: We may use and disclose your medical information in connection with the normal course of operating our practice. Health care operations may also include quality assessment activities, performance evaluations, conducting training programs, accreditation and certification, licensing or credentialing activities.

You have the following rights with respect to your protected health information which you may exercise by written request using the contact information at the end of this notice:

- The right to request additional restrictions on the use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement which must be in writing.
- The right to inspect and copy your protected health information.
- The right to request amendments to your protected health information.
- The right to receive an accounting of disclosures of your personal health information for other than treatment, payment, health care operations or pursuant to other authorized disclosures as stated above.
- The right to obtain a copy of this notice.

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we have made to amend or restrict the use or disclosure of your medical information or to have us communicate with you alternative means or at alternative locations, you may contact us using the contact information listed at the end of this notice. You may also submit a written complain to the US Department of Health and Human Services. We will provide you with the address to file you complaint upon request.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Contact: Jon Tremayne, 1600 Sunrise Ave, Ste 16, Modesto CA 95350 209.549.1600

Patient name: _____

Date of birth: ___/___/_____

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FINANCIAL POLICY:

We would like to familiarize you with how our services are billed and inform you of our financial policies. We do not want any misunderstandings; we ask that you please read our policy thoroughly. Should you have any questions, please ask our staff, who will be happy to discuss them with you.

Payment: As a friendly reminder, all co-pays, co-insurance, annual deductibles, and uncovered service fees, are expected in full at the time of your visit. For your convenience we accept cash, check, money order, and Visa, Mastercard, American Express, and Discover credit cards. We do not accept post-dated checks.

Returned Checks: There is a $25.00 charge on all returned checks. This charge is to be paid by cash or money order only.

Insurance: Tremayne Center for Medicine participates with most insurance plans. As a courtesy service, we will file your visit claim with your insurance company. It is your responsibility to make sure that we receive prompt payment. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should. If your insurance does not pay or respond to your claim within 60 days, from the date of service you will be responsible for payment.

So we can best serve you and file your insurance claims as described above, please be prepared to present your insurance card each and every time you visit our office. It is extremely important for you to notify us of any changes in your insurance coverage so we can accurately file your insurance claim for you and expedite your reimbursement.

I hereby authorize Tremayne Center for Medicine to furnish information to my insurance carrier concerning my illness and treatments and I hereby assign all payments for medical services rendered to myself or dependants.

Usual and Customary Fees: Dr. Tremayne and her staff is committed to providing you with the best treatment and care, therefore we charge what we feel is usual, customary and reasonable for our area. Our charges are based on the complexity of your problems and the amount of time it takes to care for you and your medical needs. You are responsible for payment regardless of any insurance company's arbitrary determination of what they may consider a different "usual and customary rate or fee."

After hours phone calls, TeleMed and email communications: After hours phone calls for the purpose of problem solving, information exchange, changing or refills of medications, or other therapy is considered a TeleMed appointment and will be charged to your account. TeleMed appointments are $25 or more depending on time and complexity of issue. Email communications are not considered a protected method of sensitive communications and are discouraged. Occasionally, non-specific medical information may be exchanged using email.

Missed appointments: Your appointment time is reserved for you. If you are unable to make your scheduled appointment, please call to reschedule so that a fellow patient may be given this time slot. Appointments not cancelled 24 hours in advance are subject to a $25.00 fee. For extended appointments there will be a $50 fee.

Forms: There is a fee to have forms completed by your physician. These fees will not be billed, but are due at the time the forms are dropped off or picked up. The fees are as follows:

Attending physician statement	$25.00
DMV forms	$25.00
Letter of Medical Condition	$25.00
Family Medical Leave Act	$25.00
Social Security forms	$25.00
State Disability/extension forms	$15.00
Triplicate Prescriptions	$10.00
Jury Duty Excuses	$10.00

SureScripts™: I hereby authorization Tremayne Center for Medicine to utilize SureScripts™ to automatically review my medication history for medication eligibility with my insurance company.

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HIPPA AND FINANCIAL POLICIES CONSENT:

PRIVACY AND FINANCIAL POLICIES;

ACKNOWLEDEMENT OF FINANCIAL AND PRIVACY POLICIES

The department of health and human services established the HIPPA privacy rule to protect the privacy of patient health information. In accordance with this rule I have received from Tremayne Center for Medicine, a copy of the privacy notice. Additionally, I have also received a copy of Tremayne Center for Medicine's Financial Policy. I have had full opportunity to read and consider the contents of both of these policies and agree to abide by the rules and regulations of both of these policies. This signed document will be placed in my medical chart and is valid until and unless I revoke it in writing as described below.

Signature: _____ Date: _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DISCLOSURE OF MY MEDICAL INFORMATION

I, _____, hereby authorize Dr. Tremayne to:
YOUR NAME

_____ disclose all protected health information.
_____ **I DO NOT** wish to disclose any protected health information to anyone other than for treatment, billing, and healthcare operations.

Name: _____ Relationship: _____Phone #: _____

Name: _____ Relationship: _____Phone #: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to:

Tremayne Center for Medicine
C/O Privacy Officer
1600 Sunrise Avenue, Suite 16
Modesto, California 95350

I understand that I have the right to Inspect or copy the protected health information to be used or disclosed as permitted under federal law and also to refuse to sign this authorization.

Signature: _____ Date: _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

Patient name: _____

Date of birth: ___/___/_____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

RECORDS RELEASE:

Patient name: _____ Date of Birth: _____/_____/_____

I hereby authorize: _____
Name of your previous physician and/or facility

_____
Address

_____
City State Zip

(_____) _____-_____ (_____) _____-_____
Phone number Fax number

To disclose records obtained in the course of my diagnosis and treatment to:

Tremayne Center for Medicine - Dr. Paula Tremayne
1600 Sunrise Avenue, Suite 16
Modesto, CA 95350
209.549.1600 phone 209.549.1601 fax

Information to be released: sign and date to specify which type of information is to be disclosed:

- ☐ **Complete Medical Records**
- ☐ **Mental Health Records**
- ☐ **Drug/Alcohol Records**
- ☐ **HIV-Blood Test Results**
- ☐ **Other Health Information**

Reason for disclosure: _____

AUTHORIZATION:

This authorization shall become effective immediately and shall remain in effect for 120 days (maximum) from the date of my signature. I understand that this authorization may be modified or rescinded, but that such modification or rescission will be effective only when submitted in writing. I understand that these records may be copied by Tremayne Center for Medicine, in which case I may be charged a photocopying fee of $15.00. I also understand that I have a right to receive a copy of this authorization. The recipient is prohibited from redisclosing the information without the patient's written permission unless specifically required or allowed by law.

_____ _____
Signature of patient Date

_____ _____
Signature legal representative and description of legal authority Date