

Tremayne Center for Medicine

817 Coffee Road, Suite D, Modesto, CA 95355

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 your 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, chiropractor, myofascial massage, a ketamine liaison, 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 your 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 a provider 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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Date of birth: ___/___/_____

NEW PATIENT DEMOGRAPHIC SHEET:

DEMOGRAPHICS

Who referred you? _____

Today's Date: ___/___/_____

Name: _____
LAST FIRST MIDDLE

Spouse Name: _____
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

Anemia Asthma/COPD Cancer Diabetes

Heart Disease High Cholesterol Hypertension

Kidney issues Thyroid disease Stroke

PAST SURGICAL HISTORY: year of surgery

FAMILY HISTORY: Check if applicable

Asthma Cancer Diabetes

Gout Diabetes Hypertension

Heart Attack/Disease High cholesterol

Stroke Thyroid disease

SOCIAL HISTORY:

use tobacco? Yes No If yes, how often? _____

drink alcohol? Yes No If yes, how often? _____

recreational drugs? Yes No If yes, how often? _____

exercise regularly? Yes No If yes, how often? _____

WOMEN & MEN: Check if applicable

Women: mammogram? Yes No If yes, when? _____ DEXA Yes No

Date of last vaginal PAP? _____ History of abnormal PAP Yes No

Men: Have you had a prostate exam? Yes No If yes, when? _____

Do you have pain/other issues with your penis or testicles? _____

IMMUNIZATIONS:

Influenza: _____

Pneumovax: _____

Tetanus: _____

Varucella/Shingles: _____

Patient name: _____

Date of birth: __/__/_____

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. 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, 817 Coffee Road, Suite D, Modesto CA 95355 209.549.1600

Patient name: _____

Date of birth: ___/___/_____

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 \$100-\$300 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 \$50.00 fee. For extended appointments there will be a \$100 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 to the following:

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
817 Coffee Road, Suite D
Modesto, California 95355**

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

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

817 Coffee Road, Suite D

Modesto, CA 95355

Phone: 209.549.1600 Fax: 209.549.1601

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