Western Sierra Medical Clinic
a californiahealth+ center

Pediatric New Patient Enrollment

wsmcmed.org

We are pleased to welcome you as a new patient at Western Sierra Medical Clinic.

To become established, we need your assistance and cooperation in fully completing four forms:

1. Patient Registration
2. Health Questionnaire
3. Consent to Treatment
4. Medical Records Release

In addition, we require your confirmation of receiving and reviewing Western Sierra's New Patient Welcome Packet. The packet explains your rights and responsibilities as a patient and contains policies and disclosures, as required by law.

We look forward to supporting your health and wellness.

Sincerely,

The Staff of Western Sierra Medical Clinic

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Western Sierra Medical Clinic
Better Health Together

Pediatric New Patient Registration

wsmcmed.org

PATIENT INFORMATION

o Mr. o Mrs. o Miss	Last Name	First Name	Middle
Home Address (Number and Street)		Mailing Address (if different)	
City	State	Zip Code	Patient Employed By
Home Phone ( )	Work Phone Ext. # ( ) ( )	Date of Birth	Patient Social Security Number -- --

Race (check one): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Unreported/Refused to Report

What is your ethnicity? ☐ Hispanic or Latino ☐ Not-Hispanic or Latino ☐ Refused to Report	Family Size (per household)	Annual household income	Primary Language
Sexual Orientation: ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to disclose		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Other ☐ Choose not to disclose	
US Citizen? ☐ Yes ☐ No Naturalized Citizen? ☐ Yes ☐ No	Are you a Veteran? ☐ Yes ☐ No	Are you a Seasonal Agricultural and Migratory Worker? ☐ Yes ☐ No	Are you Homeless? ☐ Yes ☐ No
In Case of Emergency Notify	Relationship to Patient	Work Phone Ext. # ( ) ( )	Home Phone ( )

Is anyone else authorized to bring your child in for a visit? (If so, Name and Relationship to Patient)

Does this person have legal authority to consent to treatment, and receive protected health information pertaining to your child? ☐ Yes ☐ No

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT

o Mr. o Mrs. o Miss	Last Name	First Name	Middle	Relationship to Patient	Home Phone ( )
Billing Address (if different from Patient's)	City		State		Zip Code
Employed By		Job Title/Department		Work Phone Ext. # ( ) ( )	
Employer Address (Number and Street)		Guarantor's Social Security # -- --		Guarantor's Date of Birth	
City	State		Zip Code		

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Group Number	Subscriber I.D.
Subscriber Name	Subscriber Date of Birth	Plan Name and Number

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Group Number	Subscriber I.D.

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Pediatric New Patient Health Questionnaire

www.wsmcmed.org

CHILD'S NAME: _____ **DATE OF BIRTH:**_____

PARENT/GUARDIAN NAME(s): _____ **DATE:** _____

Which health center do you prefer? ☐ Grass Valley ☐ Penn Valley ☐ Auburn ☐ Kings Beach ☐ Downieville

The information requested below will help us to provide better care for your child. Please take time to answer all appropriate questions. We will review the information with you to fill in details. Thank you!

1. Are there any special concerns about your child's health now?	Yes ☐	No ☐
2. Does your child take any medications at this time?	Yes ☐	No ☐
3. Your child's birth weight: _____ Was he/she born at full term?	Yes ☐	No ☐
4. Were there complications during your pregnancy with this child? (e.g. infections, use of drugs, medications)	Yes ☐	No ☐
5. Was the labor or delivery complicated? (e.g. Cesarean delivery, breech position, baby needing oxygen)	Yes ☐	No ☐
6. Did your child have problems as a newborn (e.g. jaundice, breathing trouble, infection)	Yes ☐	No ☐
7. Has your child ever been hospitalized?	Yes ☐	No ☐
8. Has your child ever had surgery?	Yes ☐	No ☐
9. Has your child had serious injuries?	Yes ☐	No ☐
10. Has your child had other medical problems?	Yes ☐	No ☐
11. Is your child allergic to anything (e.g. to medications)?	Yes ☐	No ☐
12. Are your child's vaccines up-to-date?	Yes ☐	No ☐
13. Have there been any unusual reactions to vaccines?	Yes ☐	No ☐
14. Have you ever felt that your child's growth or development were faster or slower than other children at the same age?	Yes ☐	No ☐

In the family (including the mother's and the father's families), are there any of the following?

1. Allergy problems or asthma	Yes ☐	No ☐
2. Deafness	Yes ☐	No ☐
3. Diabetes requiring insulin	Yes ☐	No ☐
4. Cystic Fibrosis	Yes ☐	No ☐

5.	Infant deaths	Yes ☐	No ☐
6.	Mental retardation	Yes ☐	No ☐
7.	Strokes or heart attacks (Before age 50 in males or 60 in females)	Yes ☐	No ☐
8.	High blood cholesterol	Yes ☐	No ☐
9.	High blood pressure	Yes ☐	No ☐
10.	Other medical problems in the family	Yes ☐	No ☐

Mother and Father are: Married ☐ Separated ☐ Divorced ☐ Remarried ☐

Mother's occupation:

_____

Father's occupation:

_____

Who lives in your child's household?

_____

Are you concerned about your child's behavior at this time? Yes ☐ No ☐

Please check any of the following symptoms that have been present in the last year:

☐ Weight loss or change of appetite
☐ Severe headaches
☐ Chronic cough or trouble breathing
☐ Muscle weakness
☐ Recurring abdominal pains
☐ Painful or excessive urination
☐ Recurring fevers without explanation
☐ Frequent constipation
☐ Vision, hearing, or speech problems
☐ Joint pain, swelling, or limp
☐ Unusual skin rashes

Other complaints or concerns?

_____

Nutrition (please leave blank):

_____

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Western Sierra Medical Clinic
Better Health Together

Consent to Treatment

www.wsmcmed.org

_____ _____

Patient's Name **Date of Birth**

The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient.

I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time.

If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol.

I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician.

This authorization shall remain effective for one year from the date signed, unless sooner revoked in writing.

_____ _____ _____

Patient, Parent, Legal Guardian or Legal Representative Guarantor Signature **Print Full Name** **Date**

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Release of Health Information

844 Old Tunnel Rd.
Grass Valley, CA 95945
wsmcmed.org

1	Patient's Last	Patient's First	Date of Birth
2	☐ Please release information/send records FROM WSMC* (To Person/Facility Below) ☐ Please release records TO WSMC (From Person/Facility Below) ***Transferring your primary care outside of WSMC may delay your appointment for specialty care.**		
3	Full Name of Organization/Provider/Individual (or Self)		
	Address		City
	State / Zip	Phone # with area code	Fax with area code
	Transmit: Verbally □ Electronic: □ Fax □ Email □ U.S. Mail: □ CD/Film □USB/Film □Paper		
4	**CHOOSE ONLY ONE (1) Per Release** ____Medical ____HIV/AIDS Testing & Treatment ____Alcohol/Substance/Drug Use Treatment ____Dental ____Behavioral Health ____ Psychotherapy Notes ____Other:		
5	**Time Frame:** ☐Last Visit ☐Past Year ☐All ☐Other:		
6	☐All records ☐Just these:		
7	**Reason for release:** ☐Personal ☐Transfer of Care ☐Other:		
Authorization	By signing, I authorize use/disclosure of my health information and understand that: • I may revoke this authorization at any time by contacting WSMC in writing. • This authorization is valid for 1 year maximum or this earlier date: ____ / ____ / ____. • The recipient of your health information may not further disclose your information without obtaining another authorization from you. • All Alcohol & Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to. • My treatment/eligibility of care is not based on this authorization. • This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original • I have the right to a copy of this authorization.		

SECTIONS 1-7 MUST BE COMPLETED TO BE VALID

Signature

_____**Date:** ____ / ____ / ____ **Tel:** (_____)_____ - _____

If not patient: ☐Patient's Representative (State Relationship_____)

PLEASE WRITE CLEARLY OR WE WILL NOT BE ABLE TO PROCESS THIS REQUEST.

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New Pediatric Patient Confirmations

www.wsmcmed.org

Print Patient Name: _____ **Date of Birth**: _____ /_____ /_____

Most of these consents, policies, and disclosures refer to
a page number in the "New Patient Welcome Packet"

Notice of Privacy Practices
_____ (Patient Initials) WSMC's Notice of Privacy Practices is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to you upon request. I read and understand WSMC's Notice of Privacy Practices.

No-Show Policy
_____ (Patient initials) I received, read and understand the WSMC policies about "No Shows."**(Page 3)**

Patient's Rights and Responsibilities
_____ (Patient initials) I received, read and understand the Patient's Rights and Responsibilities. **(Pages 4 & 4a)**

Notice and Acknowledgement of Prescription Protocol
_____ (Patient initials) I received, read and understand WSMC policy regarding controlled substances **(Page 5)**

Consent for Billing, Release and Assignments
_____ (Patient initials) All co-payments, deposits and sliding fees are due and payable at the time of check-in. I assign all insurance payments to be made directly to WSMC. This authorization and assignment is a permanent, one-time consent. I reserve the right to revoke this at any time with my written notice. **(Pages 6 & 6a)**
_____ (Patient initials) I authorize the release of information from approved claim forms to an insurer or authorized agency as well as medical information needed to determine benefits or benefits payable to related services. I also permit a copy of this authorization to be used in place of the original.

Consent to Test in the Event of Accidental Health Provider Exposure to Potential Blood-borne Pathogens:
_____ (Patient initials) I consent to the performance of a blood test if my health provider is accidentally cut or suffers a needle stick in the course of my treatment.

Verification that you have received the "New Patient Welcome Packet"
_____ (Patient initials) I received, understand and agree with all of the information in the New Patient Welcome Packet.

Specialty Care Services
_____ (Patient initials) Patients who have at least one visit annually with a WSMC provider for primary health care enjoy priority scheduling for specialty care offered through WSMC. If you are not a WSMC primary care patient who had at least one visit annually with a WSMC provider, or you transfer to an outside primary care provider, your appointment for WSMC specialty care, such as dental and Behavioral Health, may be delayed and you may be placed on a waiting list to receive specialty care. I have received, read and understand WSMC's Specialty Care Services policy.

Notices, policies and procedures subject to change
_____ (Patient initials) The above notices, policies and procedures are subject to change.

Can confidential messages be left on your voice mail? _____ Yes _____ No

Signature of Patient, Parent or Legal Guardian: _____**Date** ___ /___ /_____

WSMC Staff Signature: _____

New Pediatric Patient Welcome Packet

Welcome to Western Sierra Medical Clinic!

Western Sierra Medical Clinic, Inc. (WSMC) has been providing health care services in our community since 1979. From health centers in Downieville and Grass Valley, we have added a site in Penn Valley and expanded into Placer County with locations in Auburn and Kings Beach-Tahoe. While we have grown, our mission to provide high quality health care, regardless of a patient's' ability to pay, has remained constant. We have a team of first-rate medical, dental and behavioral health providers who are part of the community and are committed to each patient's health and wellness.

Important Patient Information

The contents of this packet spell out the policies, conditions and requirements for a patient at WSMC. It is important for every patient to read and confirm their acceptance of specific policies, disclosures and consents listed on the New Patient Confirmations form. These are requirements of WSMC and the laws and regulations that govern health center operations.

After-hours Emergencies

If you experience an after-hours emergency, you may call a Western Sierra Medical Clinic on-call provider by calling the health center where you receive care.

Western Sierra Medical Clinic
Better Health Together

ADMINISTRATIVE OFFICE
844 Old Tunnel Road | Grass Valley, CA 94945
530-273-4984 | FAX: 530-273-7255

Welcome to Western Sierra Medical Clinic!

I want to personally welcome you to our full-service health center. For many years, we have been providing compassionate, quality care. You are a vital member of our community, and your health matters to us.

Our health center has provided comprehensive care for more than 40 years to patients of a variety of ages, conditions and insurances. We are excited to extend our commitment to excellent care to you.

I have worked as a physician in this community for many years with a mission to relieve suffering and improve health. As Chief Medical Officer, I am devoted to continuing a tradition of "*better health together*" to an ever-growing population, which now includes you!

Our caring, well-trained medical staff are dedicated to helping you stay as healthy as possible by providing wellness care, dental care, behavioral health, chronic disease management, pharmacy services, and, for unexpected medical issues, urgent care.

We look forward to meeting you.

Sincerely,

Christina Lasich, MD
Chief Medical Officer

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Rev. 1-4-18

"No-Show" Policy

WSMC has established a "No-Show" policy in order to maintain quality health care to all patients of the health center.

Medical

For Medical services, a no-show is when a patient calls and cancels an appointment less than 24 hours before the appointment or the patient does not show up for a scheduled appointment.

- After two no-shows, a patient will be placed on scheduling probation, which means the patient will be able to schedule appointments but must call and confirm the appointment the day before.
- If the patient does not confirm the appointment, the appointment will be cancelled.
- If the patient shows for the unconfirmed appointment, the patient will not be seen.
- If the patient does not show for an appointment after confirming it, the patient will be considered for discharge from the practice.
- After a patient on scheduling probation demonstrates a pattern of attending appointments consistently, he or she can be considered for removal from scheduling probation.

Dental

For all Dental services, after two no-shows within one year (cancelled appointment with less than 24 hours' advance notice and/or not showing up for a scheduled appointment), the patient will not be able to schedule another appointment and may not be permitted to receive care at WSMC.

Behavioral Health

For Behavioral Health services, if a patient does not show for an appointment once, he or she will not be able to schedule another appointment and instead would be on stand-by status (the patient can come in and wait for an opening to occur) or call-in status (call in the morning to see if there is an opening on the same day). If a patient fails to show for a call-in appointment, he or she can be considered for discharge from Behavioral Health services (although he or she could still be seen for medical and dental services).

Patient's Rights and Responsibilities

Western Sierra Medical Clinic (WSMC) is committed to providing quality of care to our clients and their families. We encourage patients to be aware of their rights and responsibilities as listed below:

You Have the Right to:

1. Receive considerate, respectful, and culturally appropriate care based on professional standards of practice.
2. Receive services without discrimination on the basis of race, color, sex, marital status, religion, age, handicap, sexual orientation or preference, national origin, ancestry or diagnosis.
3. Establish advance directives and participate in ethical decision making.
4. Receive an explanation of your diagnosis, treatment, and prognosis in terms and language you can understand.
5. Receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
6. Refuse any treatment, except as prohibited by law, and to be informed of the consequences of making this decision, which may include informing Children, Youth, and Family Services or Protective Services.
7. Expect that your personal privacy will be respected by all staff.
8. Expect that your medical records will be kept confidential and information will be released only with your written consent, in cases of medical emergencies, or in accordance with law.
9. Know WSMC policy for accessing and disclosing information in your medical records and reviewing your medical record, upon request, at a mutually designated time.
10. Receive a full explanation of any research or experimental procedure proposed for treatment and the opportunity to give your informed consent before any procedure will begin.
11. Know the name and qualification of all individuals providing service and how to contact that person.
12. Obtain another medical opinion prior to any procedure.
13. Have your legal custodian access your written medical records by appointment.
14. Ask for and receive information on your financial liability and an explanation of charges, including services that will be charged to your insurance.
15. File a complaint about services rendered without fear of discrimination from WSMC by submitting a written complaint or by calling WSMC's Chief Communications Officer at (530) 273-4984 ext. 106 between 8:30 a.m. and 4:30 p.m.

Patient's Rights and Responsibilities

You are Responsible for:

1. Providing accurate personal, financial, insurance and medical information, including all medications and treatments, necessary to establish and follow your plan of care.
2. Asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis or any instructions.
3. Informing WSMC of any requirements or accommodations needed to meet your cultural and/or language needs.
4. Following rules and regulations that are posted within WSMC while in the facility.
5. Not carrying any type of weapons when receiving treatment.
6. Not harming or being abusive to other persons including WSMC staff.
7. Keeping all scheduled appointments, arriving on time, and being able to participate in treatment.
8. Notifying WSMC with 24 hours' advance notice or as soon as you are aware that you cannot keep an appointment.
9. Informing WSMC health care professionals regarding any changes or reactions to medication and/or treatment.
10. Paying for services promptly including co-payments and total of cash charges at the time of service.
11. Advising WSMC of any problems or dissatisfaction with the service being provided.
12. Extending to WSMC staff the same courtesy given to you.
13. Developing and participating in your treatment planning.
14. Providing for the supervision and safety of your children while in the facility.
15. Keeping WSMC apprised of your current contact information.
16. Not videotaping or recording any WSMC staff.

Western Sierra Medical Clinic
Better Health Together

Notice and Acknowledgement of Prescription Protocol

As a new patient to our health center, please note that your provider will make a comprehensive assessment of your health, and will work to create a health plan to best meet your health needs.

Your provider may or may not choose to prescribe the same medications that you may have been prescribed to you in the past. Our providers utilize current best practices and information to create treatment plans. You and your provider may agree that your medical condition may benefit by the prescription of controlled medication(s). The main goal of using a controlled medication is to improve your physical and vocational functioning. If these goals are not met, the medication will be discontinued. The use of controlled medications can lead to chemical dependency and possibly addiction. You and your provider will discuss the side effects of the medication(s) and the manner by which it is to be used.

If you are already dependent on controlled substances, your provider will expect you to submit urine for a drug test at your first visit. Your provider will also check the prescription drug monitoring program to determine the history of your prescription activities in the past year.

If you are currently taking **Suboxone** or **Buprenorphine**, it will be necessary for you to be referred to our Medication-Assisted Treatment (MAT) program. This could potentially delay our ability to schedule you immediately with one of our primary care providers.

During the initial evaluation, your WSMC provider may determine that the previous medications prescribed by a different provider are not appropriate, are not safe, or are causing more harm than good. If that is the case, your WSMC provider will explain the treatment plan options, which may include referral to detoxification services, tapering doses, discontinuation of medications, alternative pain management techniques, or substituting medications. If you are not in agreement with the options presented to you, you are welcome to seek care for your condition that has been treated with controlled substances elsewhere.

When prescribed a controlled substance at WSMC you will be asked at the time of your first prescription and on an annual basis to sign a treatment agreement, which is a standardized agreement that ensures that you are aware of the expectations to keep your medications secure, to take your medications as prescribed and to avoid potential dangerous situations. A copy of this agreement is available by request.

Please sign below to acknowledge that you have read this information and agree to work within this Western Sierra Medical Clinic policy.

In our continuing efforts to provide a medical home and continuity of care, we look forward to a long and mutually beneficial health relationship.

Financial Responsibility for Health Center Services (Credit Policy)

It is the patient's responsibility to pay their share of charges provided by WSMC. This means that co-payments are due and payable at the time of appointment. Except as noted, any other balances must be paid in full within thirty (30) days of the statement date.

Willingness to Pay

No one will be denied medical, dental or other clinic services at WSMC because of an inability to pay so long as there is a "willingness" to pay. Willingness means a commitment to follow a payment plan, as needed, in order to pay off any outstanding balance within 90 days. In the absence of a demonstrated willingness to pay, a patient's account will be assigned to an outside collection agency. When an account is sent for collection, the patient may be required to pay a deposit on the day of service prior to being seen for any future visits or be dismissed as a patient.

Uninsured Patient Discount

WSMC offers a 20 percent discount to uninsured patients, if charges are paid in full at the time of appointment.

Sliding Fee

For patients who qualify, a sliding scale discount may be applied for the current visit and for the next six months. A sliding scale discount may also be applied when the sliding fee application is completed for the date of service and the required proof of insurance is submitted within the 15-day calendar grace period. Please see a WSMC Billing staff member for any questions regarding the sliding fee scale.

Assignment

WSMC cannot bill insurance carriers in situations such as an automobile accident. However, WSMC will provide information to submit a claim. WSMC accepts assignments on Medicare and Medi-Cal claims but cannot make assurances that charges will be covered by the insurance carrier.

Patient Share of Charges

The patient/guardian/representative is responsible for co-payments, co-insurance, deductibles, and charges not covered or approved by the patient's insurance carrier, whether or not the carrier is contracted with WSMC. However, as a courtesy, non-contracted insurance carriers may be billed for reimbursement by WSMC on the patient's behalf. Insurance coverage can be confusing and WSMC staff is committed to helping patients answer any questions.

Identity and Insurance Verification

Patients are required to provide WSMC with correct insurance information and to verify current personal information (home address, employer, phone number, insurance cards, and photo ID) at the time of appointment check-in. **It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered.**

Payment

WSMC accepts cash, checks or major credit cards. Checks should be made payable to Western Sierra Medical Clinic.

A $25.00 fee will be charged for the first check returned by the bank and a service fee of up to $35 for each subsequent check returned by the bank to that same payee [Cal. Civ. Code 1719 (2003)].

Authorization for Release and Assignment of Benefits

Payment of authorized Medicare, Medi-Cal, government and any other third party benefits made on your behalf and/or on behalf of all members covered on your insurance plan will be made directly to Western Sierra Medical Clinic, on services furnished by your health provider.

If other health insurance coverage is indicated in the CMS-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, we require your signature to authorize release of the information to the insurer or agency shown, to release medical information to determine benefits or benefits payable to related services, and to permit a copy of this authorization to be used in place of the original.