931 Oak Park Boulevard, Suite 101
Pismo Beach, CA 93449

Dewey S. Sandberg, M.D. ~ David Ruiz, M.D.
Cary J. Fitchmun, M.D. ~ Megan M. Malzone, M.D.
Mary Lowery, M.D.

TO: _____

_____

An appointment has been scheduled for you on _____ at _____ with _____. Please arrive at _____. Please notify us as soon as possible if you are unable to keep this appointment.

Arroyo Medical Group, Inc.
931 Oak Park Blvd., Ste. 101
Pismo Beach, CA 93449
(805) 474-2600

We respect your time and would like to make your visit to our practice as efficient and helpful as possible. To assist with this, we would appreciate it if you would complete the enclosed information sheet and medical history form ahead of time and **bring them with you**, along with your medical insurance information, when you come for your appointment. Please **bring all of your current medications** and, if possible, names and addresses of your previous doctors and hospitals so that we may send for your previous medical records if necessary.

We are also enclosing information on Arroyo Medical Group and our office policies for you to read. We hope this information will be helpful to you. If you have any questions or if we can be of further assistance, please call our office at (805) 474-2600.

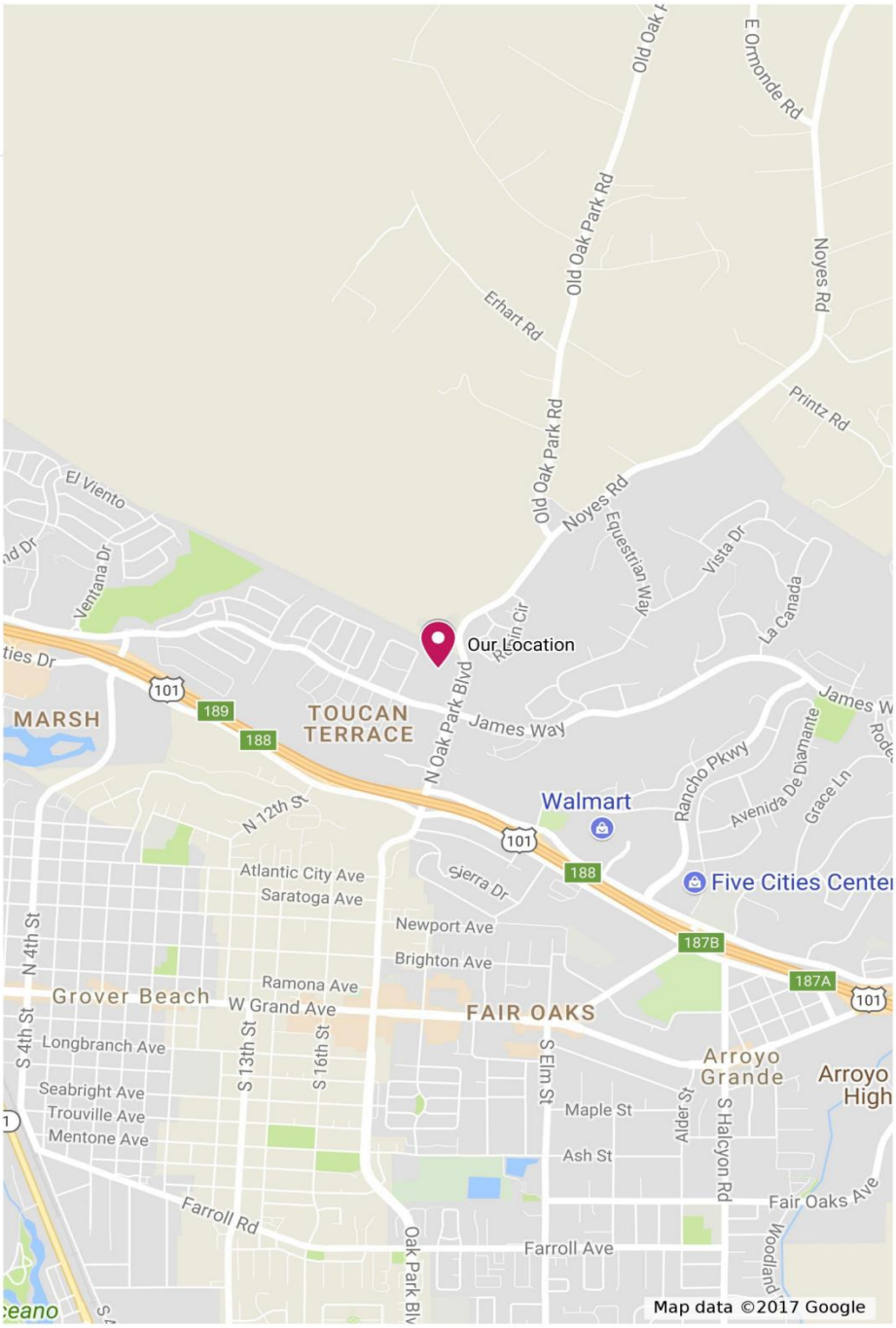
We look forward to meeting you.

The Physicians and Staff of Arroyo Medical Group

Arroyo Medical Group

931 N Oak Park Blvd, Ste 101,
Pismo Beach, CA 93449

Our Location



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MEDICAL GROUP

NEW PATIENT INFORMATION AND UPDATE (ADULT)

PLEASE PRINT

NAME: _____ AGE: _____
(LAST) (FIRST) (MI)

BIRTH DATE:_____ SOCIAL SECURITY #:_____ DRIVER'S LICENSE #:_____

SEX: ❑ MALE ❑ FEMALE
MARRIED ❑ SINGLE ❑ WIDOWED ❑ CELL #:_____ HOME PHONE #:_____

MAILING ADDRESS: _____
P.O. BOX OR STREET CITY STATE ZIP CODE
STREET ADDRESS (IF DIFFERENT FROM MAILING ADDRESS):_____

PATIENT'S OCCUPATION: _____ WORK PHONE #:_____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

SPOUSE NAME: _____ OCCUPATION: _____WORK PHONE #:_____

SPOUSE'S EMPLOYER:_____

SPOUSE EMPLOYER'S ADDRESS:_____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY?

_____
NAME PHONE # ADDRESS RELATIONSHIP TO PATIENT

<u>INSURANCE INFORMATION – PLEASE BRING YOUR INSURANCE IDENTIFICATION CARD(S) WITH YOU TO EACH OFFICE VISIT</u>
WE WILL BILL YOUR INSURANCE AS A COURTESY, PROVIDED YOU SUPPLY US WITH THE INFORMATION NECESSARY TO DO SO. IF YOU DO NOT WANT US TO BILL ANY INSURANCE FOR YOU, PLEASE CHECK HERE ❑

INSURANCE COMPANY: _____
(PRIMARY) NAME ADDRESS

PATIENT ID#: _____ GROUP #:_____

INSURANCE COMPANY: _____
(SECONDARY) NAME ADDRESS

PATIENT ID#: _____ GROUP #: _____

SUBSCRIBER RELATIONSHIP TO
NAME OF SUBSCRIBER: _____ BIRTH DATE: _____PATIENT: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:
I hereby authorize Arroyo Medical Group, Inc. to release to my insurance company any information acquired in the course of my treatment necessary to process my claim. I authorize payment of benefits directly to Arroyo Medical Group, Inc., otherwise payable to me.
I agree to be financially responsible for all services provided to me, including all insurance co-payments, deductibles, and charges not covered by my insurance contract.

_____ _____
TODAY'S DATE SIGNATURE OF PATIENT (OR AUTHORIZED REPRESENTATIVE)

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PATIENT'S INFORMATION	
NAME (Last, First, Middle)	BIRTHDATE
LOCAL PHARMACY (Name, Address, Phone Number)	MAIL ORDER PHARMACY (Name, Address, Phone Number)

REASON FOR VISIT	
Patients Injury/Illness: 1. 2. 3.	Onset Date: _____ Rate of Pain (0= no pain; 10= most severe) 1 2 3 4 5 6 7 8 9 10

ALLERGIES (Medication(s), Environmental Issue(s), and Food(s))	
Item(s) that you are *allergic* to:	Reaction(s) you have had from the *allergen,* you are allergic to:

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (brand name or generic name)	Dosage	Times taken within 24 hours	Reason for taking medication

REVIEW OF SYSTEMS: Please check boxes that apply for today's visit.

CONSTITUTIONAL:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

INTEGUMENTARY (SKIN):
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Rash
- ☐ Hives
- ☐ Skin Lesion
- ☐ Itching

HEAD, EYES, EARS, NOSE, AND THROAT:
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Eye Redness

NEUROLOGICAL:
- ☐ Dizziness
- ☐ Numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Falls

RESPIRATORY:
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Bipolar disorder

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Calf pain
- ☐ Swelling
- ☐ Palpitations

METABOLIC/ENDOCRINE:
- ☐ Cold Intolerance
- ☐ Heat Intolerance
- ☐ Excessive thirst
- ☐ Hot Flashes

GENITOURINARY:
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ Urinary retention

HEMATOLOGIC:
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ New lumps or bumps

WOMEN:
- ☐ Abnormal PAP
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ Hot flashes
- ☐ Irregular periods
- ☐ Vaginal discharge

MEN:
- ☐ Impotence
- ☐ Reduced libido
- ☐ Reduced stream
- ☐ Nighttime urination

IMMUNOLOGIC:
- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

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PATIENT INFORMATION

NAME (Last, First, Middle)	BIRTHDATE

CHRONIC PROBLEM LIST

Chronic Problem	Onset Date

PAST MEDICAL/SURGICAL HISTORY

Procedure	Year

FAMILY HISTORY (Please List only Mother, Father, Brother, and Sister)

□ PATIENT ADOPTED

□ NO RELEVANT FAMILY HISTORY

Diagnosis	Family Member	Age Onset	If deceased, age at death	Comments

SOCIAL HISTORY

TOBACCO USE:

Uses Tobacco: □ Currently □ Formerly □ Never □ Unknown

Type: □ Chewing □ Cigar □ Cigarettes □ Pipe □ Smokeless □ Snuff □ Vape

Units/Day: _____

Years Used: _____

Occupation:_____

Full time/part-time/retired: _____

Marital Status: _____

Number Times Pregnant: _____ Live Births: _____
Induced Abortions: _____ Miscarriages: _____

Number of Children: _____

Daughters: _____ # Sons: _____

ALCOHOL USE:
□ Yes □ No
□ Formerly - Year Quit _____

If "YES" –
Type of Alcohol _____

Frequency _____

When was Last Drink _____

DRUG USE:
□ Yes □ No

Type: _____

Amount Used: _____

CAFFEINE USE:
□ Yes □ No

Type:_____

Amount Daily:_____

SPECIALISTS / CONSULTANTS		SPECIALISTS / CONSULTANTS	
Name	Specialty	Name	Specialty

WHEN WAS YOUR LAST:	
Immunizations: Flu Vaccine _____ Hepatitis A_____ Hepatitis B_____ Human Papilloma Virus (HPV) _____ Meningococcal B_____ Pneumococcal, PPSV23 or Pneumovax23®_____ Pneumococcal, PCV13 or Prevnar 13® _____ Shingles, Zostavax _____ Tdap (tetanus/dipth/Pertussis) _____ Td or DT (tetanus/diphtheria)_____ TB Skin Test (PPD) _____	Diagnostic Procedures: Eye Exam _____ Mammogram _____ DEXA (Bone Density Study)_____ PAP Smear _____ Stool Blood Test _____ Colonoscopy _____ EGD (Upper Endoscopy)_____ PSA _____ Chest Xray _____ Pulmonary Function Test _____ EKG _____ ECHO _____ Treadmill _____ Angiogram/Cath _____ CT Scan_____ MRI Scan_____ Aortic Ultrasound_____ Carotid Ultrasound_____ IVP (Intravenous Pyelogram)_____ Gallbladder Sonogram _____

_____ _____ _____

Patient's Printed Name | Patient's Signature | Date Signed

The State of California requires every patient be advised of

The following:

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the

Medical Board of California

(800) 633-2322

www.mbc.ca.gov

Patient Name:_____

Patient Signature:_____

Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Arroyo Medical Group, Inc.
Privacy Officer: (805) 474-2616 – Dewey Sandberg, M.D.

I hereby acknowlege that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Print Name:_____ Date:_____

Signature:_____ Phone #:_____

If not signed by the patient, please indicate relationship:

- ❑ Parent or Guardian of minor patient
- ❑ Guardian or Conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient:_____

Financial Information

This information is to help you understand your financial obligations to your physician.

GENERAL INFORMATION:

- Arroyo Medical Group, Inc. will accept cash, personal checks, MasterCard and Visa.
- Current insurance and identification cards are required. If there are any changes to your insurance, please present your new card at the time of your appointment.
- We do not bill tertiary (third) insurance companies.
- Arroyo Medical Group, Inc. encourages you to become familiar with your health insurance plan and its benefits. Any balance unpaid by your insurance company is your responsibility.
- To protect you from imposters, your photo will be taken and kept in your electronic medical records.

CO-PAYMENTS, CO-INSURANCE, AND DEDUCTIBLES:

- Co-Payments will be collected at the time of your visit.
- If we know the amount of your co-insurance, it will be due at the time of your visit; we will collect the amount at that time. Otherwise, you will be required to pay your co-insurance within 15 days of receiving your statement from our office.
- If you have not met your deductible when your medical services are provided, you will be expected to pay your deductible at the time of service.

SELF-PAY:

- If you do not have health insurance, payment will be collected at the time of service.
- In some cases, you may make arrangements with our Business Office to make payments. Please contact the Business Office at (805) 474-2628 for more information and to arrange payments.

MEDICARE:

- If you are a Medicare beneficiary with Part B insurance, we will file your claim with Medicare.
- Payments for services not covered by Medicare will be collected at the time of your visit.

NON-CONTRACTED PLANS:

- If you are covered by an insurance company that Arroyo Medical Group, Inc. is not contracted with, and you wish to schedule with our physicians, payment will be collected in full at the time of service. We will bill your insurance company as a courtesy, and the insurance company may reimburse you directly in accordance with their rates.

NON-COVERED BENEFITS:

- Certain professional services may not be covered by health plans and are billed at a cash rate. The following are samples of non-covered services and prices. Please ask in advance about your specific form, letter, or service for a quote of the cost to complete it. Prices are subject to change. These charges are in addition to any evaluation by a physician.

- Physical Forms	$25 and up
- Jury Duty Excuses	$25 and up
- School Medication Forms	$25 and up
- Original Disability Forms	$25 and up
- Letters (any reason)	$25 and up
- Continuation of Disability Forms	$25 and up
- DMV Handicapped Placard	$25 and up
- Conservatorship Forms	$100 and up
- DMV Long Forms	$50 and up
- Original Board and Care Forms	$50 and up
- Assisted Living Forms	$50 and up
- Insurance Sickness Claim Forms	$25 and up
- Work Related Forms	$50 and up
- Life Insurance Forms	$50 and up
- Lost Prescriptions	$10 per medicine
- Lost Prescriptions (Schedule II)	$12 per medicine

AUTO ACCIDENTS AND PERSONAL INJURIES:

- If your problem is due to an auto accident or other injury, please let us know immediately so that the correct insurance information may be generated for you. As your injuries may be insured by insurance companies with whom we are not providers, payments for medical care in our office are due at the time services are rendered. We will submit an insurance claim for you, and your insurance company may reimburse you directly.
- For a fee of $0.25 per page, we can provide you with the copies of reports and paperwork required.
- We do not accept liens or letters of protection.
- If you prefer to see a different physician for your auto accident or personal injury claim, we will still see you for other medical needs.

WORKERS COMPENSATION

- Worker's Compensation is defined as any condition which results from, or is aggravated by, your job. Your regular insurance does not cover this condition.
- Our Practice does not provide care for Worker's Compensation cases. Ask your employer for a referral to a Worker's Compensation clinic.

PREVENTIVE HEALTH EXAMS:

- Routine physicals, annual exams and check-ups are examples of preventive health and will be categorized as such on any claims submitted to your health plan.
- Many plans, including Medicare, may not cover preventive visits. If you are unsure about coverage for an upcoming exam, please contact your health plan.
- **Claims will not be altered in any way once they are filed and verified to be accurate**. You will be responsible for any charges not covered by your health plan.

MISSED APPOINTMENTS AND LATE CANCELLATIONS:

- Though our office attempts to contact patients to confirm upcoming appointments, it is the patient's responsibility to manage his/her schedule and to keep appointments.
- If you need to cancel or reschedule, please contact us at least 24 hours before your scheduled appointment.
- If you have multiple no shows, you will be subject to dismissal

RETURNED CHECKS:

- Any returned check will result in a $25 service fee. Returned checks must be redeemed with cash or credit card within 14 days of being returned, or the account will be considered delinquent.
- Two returned checks within a 12-month period will place a patient's account on a cash-only status.
- If we receive a check from a closed bank account, we will submit it to the District Attorney's office.

- I HAVE READ AND UNDERSTAND THIS BINDING FINANCIAL DOCUMENT AND AGREE TO ITS TERMS.
- I UNDERSTAND THAT CHARGES NOT COVERED BY MY HEALTH PLAN ARE MY RESPONSIBILITY.
- I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO ARROYO MEDICAL GROUP, INC. WHENEVER NECESSARY. I AUTHORIZE ARROYO MEDICAL GROUP, INC. TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY TO FACILITATE PAYMENT OF A CLAIM.
- ALL QUESTIONS ABOUT THIS FINANCIAL DOCUMENT HAVE BEEN ANSWERED TO MY SATISFACTION.

COMMUNICATION PREFERENCES:

Please indicate your preferred method of communication. While we will contact you using your preferred method, in an urgent situation, we may use any of your contact numbers.

❑TEXT MESSAGE TO CELL ❑HOME PHONE ONLY ❑CELL PHONE ONLY ❑PATIENT PORTAL ❑OTHER

❑EMAIL _____

_____ _____

Patient's Name (PLEASE PRINT) Date

_____

Signature of Patient or Responsible Party

Welcome to Arroyo Medical Group, Inc.

Thank you for choosing the physicians of Arroyo Medical Group for your medical care. This notification provides an opportunity to explain important features of our medical practice. You may wish to keep this information as a reference for questions that may arise.

APPOINTMENTS:
Office visits are by appointment only. When you call for an appointment, our reception staff will ask a few questions regarding the nature and urgency of your problems or concerns. For routine health care, please call several days in advance. We always try to accommodate you if you have a physician preference; however, if your chosen physician is unavailable, we may need to arrange for you to see another Arroyo Medical Group Physician or Physician Assistant.

OFFICE HOURS
Monday – Friday
8:30 AM – 12:30 PM
1:30 PM – 5:00 PM

If you are unable to keep your scheduled appointment, we ask that you let us know at least 24 hours before your scheduled appointment time. This allows the time saved for you to be used by another patient.

EMERGENCIES:
In case of an emergency, when the situation is obviously critical or life threatening, go directly to the nearest hospital emergency room or call 911. The emergency room staff will inform us of your arrival. If you need to speak to our physician on call, outside of office hours, please call our main telephone number **(805) 474-2600** and the answering service will forward the call to the doctor on call. One of our physicians is available 24 hours a day, every day of the year. If yours is not a serious problem or an emergency, please wait until regular office hours to contact us.

OFFICE PHONE NUMBERS:
Our main telephone number is (805) 474-2600. If your call is answered by our automated system, it will be necessary for you to select an option in order for your call to be transferred.

Notice of Privacy Practices

(Revised May 2022)

During your treatment at Arroyo Medical Group, doctors, nurses, and other caregivers may gather information about your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by Arroyo Medical Group.

Arroyo Medical Group is committed to protecting patient privacy. We are required by law to provide you with this Notice of Privacy Practices and to make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; follow the terms of the notice that is currently in effect; and notify you in the event there is a breach of any unsecured protected health information about you.

I. When We May Use and Disclose Your Medical Information with Your Written Authorization

With your authorization – For any purpose other than the ones described below, we may use or disclose your health information only when you have given us your written authorization.

Marketing – We will obtain your written authorization before using your health information to send marketing materials.

Highly confidential information – There are additional protections for certain confidential health information. For example: psychotherapy notes, diagnosis, prognosis or treatment for alcohol or drug dependency, HIV testing or results, may require a special authorization.

Selling your information – We will not sell your medical information without your written authorization.

II. When We May Use and Disclose Your Medical Information Without Your Written Authorization

Payment – We may use or disclose your information to obtain payment for services provided to you.

Treatment – We may disclose your information to another health care provider so they can treat you; to provide appointment reminders; or to provide information about treatment alternatives.

Health care operations – This includes using your information for certain activities that are necessary to operate the practice and ensure that patients receive quality care. For example, we may use your information to review the performance of staff.

Reminders – To remind you of appointments or other information about new or alternative treatments or other health care services for the purposes of care coordination.

As required by law – We will disclose your medical information if we are required to do so by federal, state or local law.

Business Associates – We may disclose information about you to our business associates so they can perform the services that we have contracted them to do for us. For example, we may disclose your information to attorneys, collection and accreditation organizations.

Public health activities – We may use and disclose your medical information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Research – We may use and disclose your medical information for research purposes either with your specific, written authorization or if the research has been approved and reviewed for privacy by our Institutional Review Board. Researchers may review your health information in a limited manner to determine if the study or participants are appropriate.

Special Circumstances – We may use and disclose your medical information in these special circumstances:

- Organ and tissue donation
- Health oversight activities (as required or allowed by law)
- Judicial and administrative proceedings
- Workers' compensation
- Coroners, medical examiners, and funeral directors
- National security and intelligence activities
- Law enforcement

III. Disclosures We Make Unless You Object

We may share your health information with your family, close friends, or others involved in your care or the payment of your care if you tell us we can do so or if we can assume, based on the circumstances and our professional judgment, that you do not object. If you are unable to approve or object (for example, if you are unavailable or unconscious), we may share your health information that is related to the particular person's involvement in your care only if we feel it is in your best interest.

We may also share your health information to notify, or assist in notifying, your family, close friends, or others involved in your care of your location or general condition. For example, in a natural disaster or other emergency, we may share your health information with a disaster relief organization to assist in notifying your family of your location and general condition.

If you object to any of these circumstances, send a request to Teri Thulin, Practice Administrator, 931 Oak Park Blvd, Suite 101, Pismo Beach, CA 93449.

IV. Your Rights Regarding Your Medical Information

Right to inspect and copy your health information – You may request access to your health information to review or request copies of the information. This usually includes medical and billing records maintained by Arroyo Medical Group.

Right to receive an electronic copy of your electronic medical record – You have the right to request an electronic copy of your medical information. If the form and format are not readily producible, we will work with you to create a reasonable electronic form or format.

Right to request restrictions on the use or disclosure of your health information – You have the right to request restrictions on the use or disclosure of your medical record to your health plan for payment or health care operations if you have paid in full for the treatment out-of-pocket. This request must be in writing and identify what information you want to limit, how you want to limit the use and/or disclosure, and to whom you want the limits to apply.

Right to request to correct or amend your health information – You may ask us to correct your health information. We will consider all requests and may deny your request for legitimate reasons, for example, if we determine that the record is accurate and complete. To request a correction, you must put in writing and send to Teri Thulin, 931 Oak Park Blvd, Suite 101, Pismo Beach, CA 93449.

Right to request confidential communications – You can request that we communicate with you about medical matters in a certain way. This request must be in writing and sent to Teri Thulin, 931 Oak Park Blvd, Suite 101, Pismo Beach, CA 93449.

Right to be notified of a breach – We will notify you in the event of a breach of your protected health information.

Right to receive an accounting of disclosures of your record – You can request a list of certain disclosures we have made of your health information. This information will not include disclosures for treatment, payment, health care operations, disclosures you have authorized and certain other disclosures. To request this list of disclosures you must submit your request in writing to Teri Thulin, 931 Oak Park Blvd, Suite 101, Pismo Beach, CA 93449. If you request more than one accounting in any 12-month period, we may charge you a reasonable fee.

Right to a paper copy of this notice – You have the right to receive a paper copy of this notice and may ask for a copy at any time.

V. Changes to this Notice

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If the terms of this notice are changed, Arroyo Medical Group will provide you with a revised notice upon request and will post the revised notice in Arroyo Medical Group designated locations.

VI. Complaints or Questions

If you believe your privacy rights have been violated you may file a complaint with us by notifying our Privacy Officer, Dr. Dewey Sandberg, or the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

931 Oak Park Blvd, Suite 101
Pismo Beach, CA 93449
Main Phone – 805.474.2600 efax – 805.270.4752

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____ Today's Date_____

I request and authorize (name of current physician) _____ to release healthcare information to:

Arroyo Medical Group

efax – 805.270.4752

This request and authorization apply to **(please check)**:

- □ Healthcare information relating to the following treatment, condition, or dates: _____.
- □ All Healthcare information

I authorize the release of STD results, HIV/AIDS testing whether negative or positive, to the person(s) listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these tests to anyone. **Yes or No (please circle)**

I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above**. Yes or No (please circle)**

I understand that I may cancel this consent at any time by writing to **Arroyo Medical Group**, but that cancelling it will not affect any information that has already been released.

_____ _____
Patient Name (Print) Date

_____
Patient Signature