Welcome to Cucamonga Valley Medical Group!

We are pleased that you have chosen our medical group for your primary health care needs. In order to make your experience the best possible, we have implemented the following policies. Please read them carefully:

1. Appointments and scheduling

a) Late appointments: Your appointment may be rescheduled if you arrive more than 15 minutes late.

b) First time visit: Please arrive 30 minutes before the appointment time to complete insurance verification and the orientation process. If you have not completed your documents before your scheduled appointment time, we reserve the right to reschedule your appointment.

c) Cancellation policy/ Missed appointments: A $25 "No Show" fee will be charged to you (this cannot be billed to insurance) if you miss an appointment, or do not call to cancel your appointment 24 hours prior to your appointment time. This enables us to open up your time slot to another patient that is waiting to be seen.

d) Same Day appointments: Our best efforts will be made to accommodate same day appointments. Please call the office for availability prior to arrival.

e) Appointment requirements: In order to optimize your appointment time, please bring the following items to every visit:

i. All medications ii. Immunization record iii. Insurance card
iv. Any necessary paperwork that you need completed (see paperwork policy below)

2. Financial policies

a) Co-pay and patient share payments: Payments are required to be made in full at the time of the office visit. We accept cash, Visa, Mastercard, Discover and American Express. **We do not accept checks of any kind.**

b) Returned checks: Returned checks will incur a $25 fee in addition to check amount. After 2 returned checks, we will not be able to accept payment by personal check, and payment must be made in cash or by credit card.

c) Insurance billing: We will bill your insurance on your behalf if given all proper information. Please note that you are ultimately responsible, however, for all charges incurred.

d) Paperwork fee: A $25 fee will be applied to all paperwork requested for the physician to complete, including disability forms, FMLA forms, jury excuses, etc. We do not accept checks.

e) Medical Records fee: A $35 medical record copying fee will be charged for medical records greater than 10 pages. A higher fee may apply for records in excess of 50 pages. Checks are not accepted for payment.

3. Laboratory results

It is important to us that you receive prompt notification of lab and test results, as well as a thorough explanation of the results.

a) Pap smear results: If you have a normal pap smear, a postcard will be sent to you to inform you of the results. If the result is abnormal, you will be notified by phone to make a follow-up appointment, or with other further instructions.

b) All other laboratory tests: Even if your lab results are normal, we ask that you make an appointment to discuss the results with your doctor. In many cases, despite normal results, there will be further recommendations. *(This follow up appointment will be treated as a regular office visit, and all applicable charges and co-pays will apply.)*

c) No results received: If you do not receive a letter or a call, do not assume that the results are normal. Please call our office so that we can follow up on the results.

4. After hours policy

We have a physician on call 24 hours a day, 7 days a week. If you have an urgent medical issue, and need to speak with the doctor after hours, you may call our office and leave a message to page the physician on call. Please **do not** page the doctor for non-urgent medical issues, such as canceling or rescheduling appointments, medication refills or results inquiries. ***(Please note that if it is a life threatening medical problem, call 911.)***

5. Medication refills

a) We will not refill any narcotic or controlled medications after hours or over the phone. Ask your doctor for sufficient refills at the time of your visit to last until your next appointment (typically 3-6 months). Please check with your pharmacy to see if you have any refills already approved before calling the office.

b) If you are on any chronic medications, your doctor will, in most cases, want to see you every 3-6 months to monitor the medications and their efficacy in treating your condition. It is for this reason that, if you have not been in to see the doctor in several months, that the refill may be denied.

c) We are pleased to announce that we now support the Sure Scripts service for electronic prescriptions. If your pharmacy uses this service, and you need a refill, please call your pharmacy and they will contact the office for refill authorization on your behalf.

I, ▶ _____, have read and
PATIENT NAME (PRINTED)
received a copy of Cucamonga Valley Medical Group's policies.

▶ _____ ▶ _____
SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR) DATE

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CUCAMONGA VALLEY™
MEDICAL GROUP

Patient Registration

Welcome to Cucamonga Valley Medical Group. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Information

PATIENT NAME | TODAY'S DATE | DATE OF BIRTH | AGE | GENDER (M / F)

PARENT (IF PATIENT IS A MINOR) | PATIENT'S RACE | MARITAL STATUS

PATIENT'S SOCIAL SECURITY NUMBER | PATIENT'S DRIVER'S LICENSE NUMBER

HOME ADDRESS | CITY | STATE | ZIP CODE

MAILING ADDRESS (WRITE "SAME" IF SAME AS HOME) | CITY | STATE | ZIP CODE

☐ Cell ☐ Home
PRIMARY CONTACT NUMBER AND NAME OF CONTACT

☐ Cell ☐ Home
SECONDARY CONTACT NUMBER AND NAME OF CONTACT

WORK PHONE | EMAIL ADDRESS

OCCUPATION | EMPLOYER'S NAME (SCHOOL NAME IF FULL-TIME STUDENT)

EMPLOYER'S ADDRESS (SCHOOL ADDRESS IF FULL-TIME STUDENT) | CITY | STATE | ZIP CODE

HOW DID YOU HEAR ABOUT OUR PRACTICE?

Emergency Contact Information: Who We Should Notify in Case of Emergency

PRIMARY CONTACT NAME | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME TELEPHONE | WORK TELEPHONE | CELL PHONE

SECONDARY CONTACT NAME | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

HOME TELEPHONE | WORK TELEPHONE | CELL PHONE

Guarantor Information: Person Responsible For Fees / Insured Party

NAME | RELATIONSHIP TO PATIENT

ADDRESS | CITY | STATE | ZIP CODE

☐ Cell ☐ Home
PRIMARY CONTACT NUMBER

☐ Cell ☐ Home
SECONDARY CONTACT NUMBER

WORK PHONE

INSURANCE COMPANY | CLAIM ADDRESS

SUBSCRIBER'S NAME | **SUBSCRIBER'S DATE OF BIRTH** | **SUBSCRIBER'S SOCIAL SECURITY NUMBER**

INSURANCE ID NO.

SECONDARY INSURANCE | CLAIM ADDRESS

SUBSCRIBER'S NAME | **SUBSCRIBER'S DATE OF BIRTH** | **SUBSCRIBER'S SOCIAL SECURITY NUMBER**

☐ Yes ☐ No
WERE YOU INJURED ON THE JOB?

☐ Yes ☐ No
HAVE YOU INFORMED YOUR EMPLOYER?

16465 Sierra Lakes Parkway | Ste. 300 | Fontana, CA 92336 ::: 1175 E. Arrow Highway | Ste. B | Upland, CA 91786
909.429.CVMG [2864] | www.cvmgdocs.com | fax 909.429-2868

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Health History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible.

LAST NAME | FIRST NAME | BIRTHDATE | M F GENDER

PRESENTING PROBLEM

Illness / Injury: (Please check if you have ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ Heart Murmur
- ☐ Stroke
- ☐ Cancer (Please List Type)
- ☐ Hepatitis
- ☐ Kidney Stones
- ☐ Blood Transfusion
- ☐ Diverticulosis/Itis
- ☐ Thyroid Problem
- ☐ Lung Problems/Asthma
- ☐ Gallstones
- ☐ Exposure To Tuberculosis
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELCTIONS, IF ANY

Family History: (Please check if an immediate family member– parents or siblings, has ever had)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer (Please List Type)
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Problems (Please List)
- ☐ Other (Please List)

PLEASE LIST DETAILS OF ABOVE SELCTIONS, IF ANY

Operations/Surgeries: (Please list names and dates of all operations you have had)

☐ None

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

NAME OF OPERATION | YEAR | COMPLICATIONS

Medications: (Please list all medications and dosages, including over-the-counter and supplements)

☐ None

NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY

NAME OF MEDICATION | DOSAGE AND FREQUENCY

Allergies: (Please list any medication allergies and reaction)

☐ None

NAME OF MEDICATION | REACTION

NAME OF MEDICATION | REACTION

NAME OF MEDICATION | REACTION

NAME OF MEDICATION | REACTION

Other Information:

Do you now use tobacco? ☐ Yes ☐ No — TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used tobacco? ☐ Yes ☐ No — QUIT DATE

Do you drink alcohol? ☐ Yes ☐ No — TYPE | AMOUNT / DAY | NO. YEARS

Have you ever used alcohol? ☐ Yes ☐ No — QUIT DATE

Do you use street drugs? ☐ Yes ☐ No — TYPE(S) | ☐ Yes ☐ No INTRAVENOUS | NO. YEARS

Have you ever used street drugs? ☐ Yes ☐ No — QUIT DATE | TYPE(S) | ☐ Yes ☐ No INTRAVENOUS

Do you have an Advance Directive for Health Care? ☐ Yes ☐ No | Would you like more info on Advance Directives? ☐ Yes ☐ No

The above information is true and accurate.

SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF PATIENT IS A MINOR) | DATE

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