KELLY A. SHARRAR, M.D

REGISTRATION FORM

(Please Print)

Today's date:	PCP if other than above:

PATIENT INFORMATION

Cell Phone:_____

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no. for insurance verification:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Preferred Pharmacy: H ow did you hear about our clinic? (check one):

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other ❑ Insurance Plan ❑ Hospital

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) Card on file? Yes | No

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Medicare ❑ Anthem Blue Cross PPO ❑ Blue Shield PPO ❑ Aetna PPO ❑ Cigna PPO ❑ HealthNet PPO ❑ Tricare Federal ❑ Medi-Cal ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kelly A. Sharrar, M.D or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NEW PATIENT HEALTH HISTORY FORM

Patient Name: _____ **Birth date**: ____/____/____ **Date**: ____/____/_____

Referring Physician: _____ Address: _____
Pharmacy Name: _____ Phone Number: _____-_____-_____

Reason for today's visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	CURRENT/ PRIOR ILLNESSES/ INJURIES

Please list ALL medications (prescription and non- prescription) that you take. (Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE
Last Flu Shot? Last Tetanus?		Pneumo-Vax? Shingles Vax?	

Do you take any blood thinning products such as **Vitamin E, Plavix, Coumadin, or Aspirin**? ☐ **NO** ☐ **YES**

Do you have any food, environmental, or drug allergies? ☐ **NO** ☐ **YES** (Please explain below)

ALLERGY	TYPE	REACTION

Do you smoke? ☐ **Never have** ☐ **Not Anymore**(Please explain below) ☐ **YES** (Please explain below)

TYPE OF SMOKING (cigarette, pipe marijuana, chew, etc.)	HOW MUCH	HOW LONG

Married / Single / Divorced / Widowed #Children # Pregnancies

Do you drink alcohol? ☐ **NO** and Never have ☐ **Socially Only** ☐ **Daily** ☐ **Beer/ Wine** ☐ **Hard Liquor**

Occupation: _____ Hand Dominance: ☐ **RIGHT** ☐ **LEFT**

Other Recreational Drug Use? List type and frequency _____

FAMILY HISTORY	GOOD/ NONE	UNKNOWN	ILLNESSES/ REASON FOR DEATH
MOTHER			
FATHER			
SIBLING(S)			
OTHER HEREDITARY ILLNESS			

Patient Signature: _____ Date: ____/_____/_____

Physician Signature: _____ Date Reviewed: ____/____/____

HEALTH HISTORY FORM 2

Do you have or have you ever had any of the following:

Symptoms/ Illness	NO	YES, Explain	Symptoms/ Illness	NO	YES, Explain
Constitutional			**Skin**		
Fever or Chills			Breast Abnormalities		
Weight Loss			Nipple Discharge		
Hematologic			**Last Mammogram**		**Date: ____/____/____**
Hepatitis			Changes in Moles		
HIV/ Other Blood Diseases			Lesions		
Bleeding Disorders			Rashes		
Endocrine			History of Keloids		
Thyroid Problems			**Neurological**		
Diabetes			Neurological Problems		
Musculoskeletal			Headaches		
Arthritis			**GENITOURINARY**		
Mobility/ Joint Problems			Genital or Oral Herpes		
GASTROINTESTINAL			S.T.D.'s		
Constipation			Blood in Urine		
Diarrhea			Urinary Tract Infection		
Blood in Stool			Problems Urinating		
Nausea/ Vomiting			Prostate Problems		
Liver Problems			Kidney Problems		
CARDIOVASCULAR			**Eyes**		
Heart Problems			Vision Problems		
Deep Vein Thrombosis/ DVT			**ENT**		
Blood Clots in Lungs/ Legs			Hearing Problems		
High Blood Pressure			Sinus Problems		
RESPIRATORY			**PSYCHIATRIC**		
Asthma			Mood Swings		
Sleep Apnea			Anxiety/ Depression		

Please list any other conditions/ illnesses not indicated above: _____

_____

To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes to my health.

Patient Signature: _____ Date: ____/____/____

Physician Signature: _____ Date Reviewed: ____/____/____

Kelly A. Sharrar, M.D. Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed):

Date of Birth:

Notice of Privacy Practices/clinics.

_____ (Patient/Representative initials) **I understand that the practice/clinic's Notice of Privacy Practice is available on their website, www.mariposadoctor.com**, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics. **I acknowledge that I can receive a printed copy at my request.**

Consent to Treat

1. I give permission for **Kelly A. Sharrar, M.D.** to give me medical treatment.
2. I allow **Kelly A. Sharrar, M.D.** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Kelly A. Sharrar, M.D.** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date

(for children under 18)

_____ _____

Print name

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL INFORMATION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Please write in any specific conditions/results you do not want discussed with designated individuals.

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent _____ (Patient/Representative initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ (Patient/Representative initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge

for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.
I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is**_____.

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.
I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.
I decline _____ (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:
    - Name: _____ Date: _____
    - Name: _____ Date: _____
- ***I do not want*** _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____

Date: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ _____
(Name of Patient) (Date of Birth)

hereby authorize _____
(Name of person or facility which has information)

to release the following health information: ALL MEDICAL RECORDS

To:

KELLY A. SHARRAR, M.D. (FAMILY PHYSICIAN)
(Name and title or facility name to receive health information)

4981 INDIAN PEAK RD, MARIPOSA, CA 95338 (209) 682-5228 (209) 682-5227
(Street address, city, state, ZIP code) (Telephone number) (Fax number)

For the following purposes: **CONTINUING MEDICAL CARE**

This authorization is in effect until _____ (date or event), when it expires.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

Signed by Patient: Print Name:	Date
Or Signed by Personal Representative: _____ On Behalf of _____ Name of Patient	Date

Office Policy Updates

Please review these updates to our office policies. *Please initial each line item* and sign and date at the bottom of the page.

_____ Dr Sharrar will be adding 15 minute appointment slots for urgent medical form processing. If you need Medical Forms filled out, that can not wait until your next appointment, please call the office (209) 682-5228 or text 209 682 5248. We will do our best to get you in within 48 hours. Payment for this last minute service is $30, and due at the time of service.

_____ Chronic pain care is managed by a referral to a Chronic Pain Care Specialist or Clinic. Dr Sharrar does not prescribe any medications that fall under The Controlled Substance Act

_____ Patients without insurance are welcome. Estimated Payment will be collected during check in. Any additional fees will be collected at the end of the appointment. If you are unable to pay for your visit during check in, your appointment will be rescheduled.

_____ Copays are due at check in. Payment options: Cash, check, or debit/credit. Debit/credit cards are subject to a 4% surcharge charge, and paid directly to the processing company.

_____ Missed appointments or appointments canceled with less than 24 hours notice are subject to a $125 fee.

Signature Date

Printed Name