



1111 E Warner Street, Ste 101, Fresno, California, 93710

Office: (559) 512-7313 Fax: (559) 512-7153

Patient Profile

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SSN: _____

Gender:

☐ Male ☐ Female ☐ Other

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Widowed

Preferred Pharmacy & Location: _____

Contact Information

Home Phone: _____ Mobile Phone: _____

Email Address : _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Current Employer: _____ Job Title: _____

Health Insurance Carrier: _____ **Cardholder:** _____

Cardholder Birthday: _____ Cardholder SSN: _____

Relationship to Cardholder ☐ Male ☐ Female ☐ Other

Subscriber ID# _____ Group ID# _____

Emergency Contact Information

First Name: _____ Last Name: _____ Relation: _____

Home Phone: _____ Mobile Phone: _____

By providing your phone number or email address, you consent to receiving communications related to medical follow-up, lab results, and general medical information.

Patient/Guardian Signature

Date



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Pain Management Agreement

Patient Name

First Name: _____ Middle Initial: _____ Last Name: _____

Date: _____

The purpose of this agreement is to ensure responsible and safe use of prescribed pain medication provided by Central California Hospital Medicine Group. Effective pain management requires clear communication, mutual trust, and adherence to the policies outlined below.

Patient Responsibilities

1. Use of Prescribed Medication

- I agree to take pain medication exactly as prescribed by my physician at Central California Hospital Medicine Group.
- I will not adjust my dosage or frequency without prior authorization from my prescribing physician.

2. Single Provider Clause

- I agree that all pain medications will be prescribed exclusively by Central California Hospital Medicine Group.
- I will not seek pain medication prescriptions from any other healthcare provider without explicit permission from Central California Hospital Medicine Group.
- I understand that obtaining pain medications from another provider without approval will result in the termination of my patient relationship with Central California Hospital Medicine Group.

3. Medication Safety

- I am responsible for securing my medications. Lost, stolen, or misplaced medications will not be replaced under any circumstances.

4. Reporting Changes

- I will immediately inform Central California Hospital Medicine Group of any changes in my medical history, including new medications or treatments from other providers.

Patient/Guardian Signature

Date



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Financial Policy

Your signature below forms a binding agreement with Central California Hospital Medicine Group and the Patient who is receiving medical services or the Responsible Party for eligible dependents. The Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service. We strive to establish financial arrangements prior to treatment. Pre-arranged financial options are available. Please ask our office personnel for more information.

We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. The person signing on behalf of the patient as the Responsible Party must inform Central California Hospital Medicine Group of the current address, phone number, and birth date of the patient and the responsible party. Present all current insurance cards with each office visit. Pay any required co-pay at the time of the visit. Pay any additional amount owed within 30 days of receiving a statement from our office. (When Central California Hospital Medicine Group receives an explanation of benefits (EOB) from your insurance company, any amount that you need to pay will be billed to you.)

Cash, Check, Mastercard, Visa, American Express, and CareCredit are all accepted forms of payment. If a payment is made on an account by check and the check is returned as Non-Sufficient Funds (NSF) or Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a \$50.00 service charge for the returned check.

Should collection proceedings or other legal action become necessary to collect an overdue account, the Patient or the patient's Responsible Party understands that Central California Hospital Medicine Group has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the Responsible Party for a minor patient. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name: _____

Date of Birth _____

Patient/Guardian Signature

Date



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Practice Policies

1. Monitoring and Compliance

- I understand that Central California Hospital Medicine Group may require drug testing or other compliance measures to ensure proper use of prescribed medications.

2. Refills

- Refills will only be provided during regular office hours and must be requested at least 48 hours in advance. Refills will not be given after hours or at weekends.

3. Violation of Agreement

- Any violation of this agreement, including seeking medications from other providers without approval, will result in the immediate termination.

4. Emergency Situations

- If I experience a medical emergency, I will contact Central California Hospital Medicine Group immediately or visit the nearest emergency room.

Acknowledgement and Agreement

I acknowledge that I have read and fully understand the terms of this Pain Management Agreement. I agree to comply with these terms and understand that failure to do so may result in the discontinuation of my care at Central California Hospital Medicine Group.

Patient Signature

Date

Provider Signature

Date

Thank you for entrusting your care to Central California Hospital Medicine Group. We are committed to your health and well-being.



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HIPPA General Medical Release Form

I hereby authorize the disclosure of my medical information by:

Name of person authorizing release of information:

Patient's name: _____ DOB: _____

Street address: _____

City: _____ State: _____ Zip code: _____

Phone: _____

To release my information to:

Name/Relationship: _____ DOB: _____

Name/Relationship: _____ DOB: _____

Name/Relationship: _____ DOB: _____

Name/Relationship: _____ DOB: _____

This authorization applies to the following: Check box if authorized for the release of medical information.

All records: Yes _____

Labs: Yes _____

Imaging Reports: Yes _____

Immunizations: Yes _____

Name (printed): _____

Signature

Date



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Patient Health Questionnaire (PHQ-9)

Patient's name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(circle the number to indicate your answer)

	Not At All	Several Days	More than half	Nearly Every Day
1. Little interest or pleasure in doing things.	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless.	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep or sleeping too much.	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy.	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating.	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself, feeling you are a failure, or having let yourself or your family down.	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed, or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead, or thoughts of hurting yourself.	0 ☐	1 ☐	2 ☐	3 ☐

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

(Healthcare Professional: Please refer to
scoring card)



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Patient History

Patient's name: _____ Gender: _____

Do you have allergies to medication or foods? Yes / No

Name of allergies	Symptoms

Do you have any histories of medical problems? (check all that apply)

- ☐ Hypertension ☐ Osteoporosis ☐ Hyperlipidemia ☐ Cancer ☐ Diabetes Type I
- ☐ Asthma ☐ Diabetes Type II ☐ COPD ☐ Coronary Artery Disease ☐ Stroke
- ☐ Alzheimer's ☐ Depression

Are you a smoker? Yes / No. If yes, how many years? _____

Are you an ex-smoker? Yes / No.

If yes, how many years have you smoked and when did you stop? _____

Do you drink alcohol? Yes / No. If yes, how many drinks per week? _____

Do you do drugs? Yes / No. If so, please provide the name? _____

I certify that the information provided on this form is true, complete, and accurate to the best of my knowledge. I understand that providing false or misleading information may affect my medical care and may have legal or financial consequences. By signing below, I acknowledge that the information submitted is truthful and correct.

Signature

Date



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Medications

Patient's name: _____ Gender: _____

Medication Name	Dose	Indication

Circle or check if applicable

Flu Shot: ☐ Done ☐ Needs Vaccine

Tdap: ☐ Done ☐ Needs Vaccine

MMR: ☐ Done ☐ Needs Vaccine ☐ Draw Titer

Varicella: ☐ Done ☐ Needs Vaccine ☐ Draw Titer ☐ History of Varicella

Hepatitis B: ☐ Done ☐ Needs Vaccine ☐ Draw Titer

COVID: ☐ Complete Series ☐ Needs Vaccine

Recent Physical ☐ Yes ☐ No

Requires Additional Blood Testing for Physical ☐ Yes ☐ No

Signature

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Telehealth Consent & Authorization

Patient's name: _____ Date of Birth: _____

PURPOSE

The purpose of this form is to obtain your informed consent to participate in telehealth services provided by Central California Hospital Medicine Group ("CCHMG"). Telehealth includes the use of electronic communications or other means of information technology.

WHAT IS TELEHEALTH

Telehealth may include evaluation, diagnosis, consultation, treatment, and follow-up care using electronic communication.

RISKS, LIMITATIONS & BENEFITS

By signing this form, you acknowledge and understand: Telehealth services may have limitations compared to in-person visits. There may be technical failures (e.g., poor connection, interruptions). There is a potential risk of unauthorized access to your health information despite reasonable safeguards. Not all conditions can be appropriately diagnosed or treated via telehealth. Improved access to care. Reduced travel time and associated costs. Timely medical evaluation and follow-up.

CONFIDENTIALITY & PRIVACY

My information will be protected in accordance with HIPAA and California law. Telehealth sessions will not be recorded without my consent.

PATIENT RIGHTS

You have the right to: Refuse or withdraw consent for telehealth at any time without affecting your right to future care or treatment. Request an in-person visit instead of telehealth services. Ask questions regarding telehealth services, risks, and alternatives.

PATIENT RESPONSIBILITIES

You acknowledge that: You are responsible for providing accurate medical information. You need access to a device (computer, tablet, or smartphone) and reliable internet connection.

FINANCIAL RESPONSIBILITY

I understand that telehealth services may be billed to my insurance and I am responsible for any applicable co-pays, deductibles, or non-covered services.

Signature

Date