**Ajaipal S. Gill, M. D., Inc.**

**1215 Plumas Street, Suite 1800**

**Yuba City, CA 95991**

**530-749-9270**

**PATIENT INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: M \_\_\_ S \_\_\_ D \_\_\_ Other: \_\_\_\_\_

(If necessary, messages regarding your health care

and appointments will be left at the home phone

number you provide below, unless you advise us

otherwise)

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_\_

Drivers Lic. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S INSURANCE INFO:**

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Address (if different than patient):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2ND/ OTHER INSURANCE:** (if any)

Insurance Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPONSIBLE PARTY:**(if other than patient)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S SPOUSE OR GUARDIAN:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Guardian

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Life Time Assignment of Benefit/ Information Release/ Authorization to Treat:**

I authorize payment of medical benefits to **Ajaipal S. Gill M.D., Inc.** for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier (payment for **co-pays or deductibles** are due at time of service). I authorize you to release my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge and fully understand that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I have been given the opportunity to ask questions regarding my diagnosis, treatment, and the necessary information to make a proper diagnosis for certain conditions.

I also acknowledge and understand that sleep testing procedures including set up and unhooking of the device is conducted under video monitoring as per practice guidelines and standards established by American Academy of Sleep Medicine.

I have received a copy of my Patient Rights and Responsibilities, Grievance procedure, and information regarding advance directives.

**PATIENT OR GUARDIAN SIGNATURE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ajaipal S. Gill M.D, Inc.**

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***Diplomat American Board of Internal Medicine,***

***Pulmonary Medicine and Sleep Medicine***

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*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

**I hereby authorize the use or disclosure of my individually identifiable health information as described below.** I understand that Ajaipal S. Gill M.D. Inc. takes no responsibility on behalf of a person or entity to whom the information is disclosed to comply with Federal Privacy Regulations.

1. Specific description of information that may be used/disclosed:

MEDICAL RECORDS

2. The information will be used/disclosed for the following purpose(s):

CONTINUANCE OF CARE

3. Persons/organizations authorized to use or disclose the information:

Ajaipal S. Gill M.D. Inc.

4. Persons/organizations authorized to receive the information:

REFERRING PHYSICIAN / DURABLE MEDICAL EQUIPMENT PROVIDER

5. If the purpose of this authorization is to disclose health information to another party based on health care that is

provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to

deny that health care.

6. I understand that I may inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the

extent that action has been taken in reliance on this authorization.

8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.

9. This authorization expires on [upon] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or patient’s representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of patient or patient’s representative Relationship to patient or representative’s authority to act for the patient, if applicable

**A copy of this signed form will be provided to the patient, if requested.**

**Ajaipal S. Gill M.D., Inc.**

**NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Our facility uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our facility.

**How We May Use or Disclose Your Health Information**

**For Treatment.** We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, therapist, nurse, or other person providing health services to you, will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions take by them in the course of your treatment and note how you respond.

**For Payment**. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

**For Health Care Operations**.We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

• evaluate the performance of our staff;

• assess the quality of care and outcomes in your cases and similar cases;

• learn how to improve our facilities and services; and

• determine how to continually improve the quality and effectiveness of the health care we provide.

**Appointments.** We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Required by law**. We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

• for judicial and administrative proceedings pursuant to legal authority;

• to report information related to victims of abuse, neglect or domestic violence; and

• to assist law enforcement officials in their law enforcement duties;

**Public Health**. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

**Decedents**. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

**Health and Safety**. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

**Government Functions**. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

**Workers’ Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers’ Compensation.

**Other uses**. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken action in reliance on such.

**Your Health Information Rights**

You have the right to:

• request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.522; however, our facility is not required to agree to a requested restriction;

• obtain a paper copy of the notice of information practices upon request;

• inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;

• request that your health record be amended as provided in 45 C.F.R. §164.526;

• request communications of your health information by alternative means or at alternative locations; and

• receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

**Concerns/Complaints**

You may complain to our facility and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Managing Employee or complete and return a Patient Concern Form to our facility.

**Our Obligations**

Our facility is required by law to:

• maintain the privacy of protected health information;

• provide you with this notice of its legal duties and privacy practices with respect to your health information;

• abide by the terms of this notice;

• notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;

• accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

We reserve the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

**Contact Information**

If you have any questions or complaints, please contact: 530-749-9270

By signing this document, I acknowledge that I have received a copy of **Ajaipal S. Gill M.D., Inc.**

Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Print) Signature Date

**Ajaipal S Gill, M.D., Inc.**

**Patients’ Rights and Responsibilities**

We are committed to serving you with compassion, care, skill, and respect. **Ajaipal S. Gill M.D., Inc.**

does not discriminate on the basis of sex, age, creed, race or national origin. As one of our patients, you have choices, rights and responsibilities.

**You have the *RIGHT*:**

• to be treated with dignity and respect

• to know the names and professional status of people serving you

• to privacy

• to confidentiality of your records

• to receive accurate information about your health-related concerns

• to know the effectiveness, possible side effects and problems of all forms of treatment

• to participate in choosing a form of treatment

• to receive education and counseling

• to consent to, or refuse, any care or treatment

• to select and/or change your health care provider

• to review your medical records with a clinician

• to file a concern or grievance

• to fair and humane treatment

• to information about services and any related costs

• to self-determination; including the right to make choices about life-sustaining treatment

**You also have the *RESPONSIBILITY***:

• to seek medical attention promptly

• to be honest about your medical history

• to ask about anything you do not understand

• to follow health advice and medical instructions

• to report any significant changes in symptoms or failure to improve

• to respect clinic policies

• to keep appointments or cancel in advance

• to seek non-emergency care during regular business hours

• to provide useful feedback about services and policies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Ajaipal S Gill, MD. Inc.**

**PATIENT COMPLIANT/ GRIEVANCE PROCESS**

It is the policy of Ajaipal S Gill, M.D., Inc. to provide for a systematic approach to resolving conflicts that may arise concerning the care of a patient. Patients have the right to communicate complaints regarding the care received, to have those complaints investigated and when possible, resolved. Patient complaints will in no way affect future access to health care. Any patient and/or designated representative, who present a conflict in the care the patient is receiving, shall be encouraged to address that issue with the Practice/ Facility Office Manager/ compliant officer. If patient designated representative wishes to file a complaint/grievance, they may contact the Compliant Officer/ Office Manager at 530-749-9270.

**Advance Directives**

**Available Fee on Line**

[www.uslivingwillregistry.com](http://www.uslivingwillregistry.com)

Click on – Advance Directive Forms, Click on – California Print

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**Authorization to leave message on answering machine**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give Dr Gill and/or staff permission to leave messages on my machine concerning appointments, lab work, etc.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION TO GIVE MY PERSONAL HEALTH CARE INFORMATION**

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

1. Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If for some reason you request, or we need to send your records somewhere, do we have your authorization to send them via fax?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_No

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (guardian) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Phone (530) 749-9270 Fax (530) 749-9259*

**Office Cancellation Policy**

We recognize how valuable your time is; therefore, our office policy is to schedule your appointment as effectively as possible.  A charge will be assessed per patient for each appointment that is not kept or is not given adequate twenty-four hour notice prior to cancellation or rescheduling.  Notification of cancellation or rescheduling through the answering service, after working hours, over the weekend or holidays will not be considered acceptable to avoid these charges, as we do not receive these messages until the following normal business hours.  We realize emergencies occur and this will always be taken into consideration.

Our office policy to assess the following charges for inadequate notice of cancellation or rescheduling is as follows:

Office Follow Up Visit $40.00

Consultation Visit $50.00

Office Procedures $40.00

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patients Signature Date

***Ajaipal S. Gill M.D. Inc***

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Since your last follow up have there been any changes to your insurance? If so please provide new insurance cards.

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_\_\_ No

Do you reside in a skilled nursing facility?

\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_No

Are you in hospice?

\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature/Date