Dr. Richard Uhler
31493 Rancho Pueblo Rd, Suite 203
Temecula, CA 92592
Ph: 951-693-9678
Email: reuhler@yahoo.com

Welcome to the office of Dr. Richard Uhler. Please take the time to **complete all** of the attached forms. Even though copies of insurance and identification cards are required, we ask you to complete the information in full. We bill your insurance as a courtesy to you. We are unable to bill insurance companies without the following information. If you have any questions, please feel free to ask for assistance.

HEALTH INFORMATION FORM
PATIENT INFORMATION (Please write clearly)

Patient Name: _____ SSN: _____ Age: _____
Birth Date: _____/_____/_____ Sex: M F Phone: _____ ☐ Married ☐ Single ☐ Widow ☐ Divorced
Address: _____ City: _____ State: _____ Zip: _____
Email address: _____ Race: _____ Ethnicity: _____
Emergency contact: _____ Relationship: _____ Phone: _____
☐ Employed ☐ Student: ☐ F/Time ☐ P/Time Employer or school name: _____
Reason for visit: _____ Referred by: _____ Date it began/happened: _____
Pharmacy used for medications: _____ Location: _____

NAME OF PERSON WHOSE INSURANCE IS BEING BILLED

Relationship of Patient: Child Self Spouse Other (Circle One) Phone: _____
Name: _____ SSN: _____
Birth Date: _____/_____/_____ Sex: M F Drivers License No. _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Employee Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION (List all information according to insurance card)

Insured's Name: _____ SSN: _____ Birth Date: _____/_____/_____
Insurance Name: _____ Type of Insurance: PPO POS EPO Other:
ID Number: _____ Group No. _____ Effective Date: _____/_____/_____

SECONDARY INSURANCE INFORMATION (List all information according to insurance card)

Insured's Name: _____ SSN: _____ Birth Date: _____/_____/_____
Insurance Name: _____ Type of Insurance: PPO POS EPO Other:
ID Number: _____ Group No. _____ Effective Date: _____/_____/_____

SIGN AND DATE

I declare the above information to be true and correct. I understand I am financially responsible for any amounts not paid by my insurance.

Signature of Patient/Insured/Guarantor: _____ Date: _____

WELCOME TO OUR PRACTICE. AS A NEW PATIENT, PLEASE FILL OUT THE INFORMATION FOUND BELOW TO THE BEST OF YOUR ABILITY.

Patient Name: _____ Date: _____

Chief Complaint: _____ Birth date: _____

History of present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Ex. normal vs abnormal color, activity etc.)

Severity: _____ (How severe is the pain/problem on a scale of 1-5 with 5 being most severe)

Duration: _____ (How long have you had this pain/problem Or, when did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain problem?)

Associated signs/symptoms: _____ (What other associated problems have you been having?)

Modifying Factors: _____ (What makes the pain/problem worse or better? Or, have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes
Mumps	no	yes	Bladder Infection	no	yes	High Blood Pressure	no	yes
Chicken pox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last Chest X-ray		
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes
Venereal Disease	no	yes	Ulcer	no	yes	Stroke	no	yes
Hepatitis	no	yes	Bleeding Tendency	no	yes	Kidney Disease	no	yes
Thyroid Disease	no	yes						
Any other disease	no	yes						

(Please list) _____

Have you ever taken Phen-Fen/Redux? no yes

Patient Previous/Current pcp _____

PCP # Phone (_____) _____-_____
PCP Fax # (_____) _____-_____

HEALTH HISTORY

Review of Systems
Please indicate any personal history:

☐ **Constitutional Symptoms**

Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes
Headaches	no	yes

☐ **Eyes**

Eye disease or injury	no	yes
Wear glasses/contact lenses	no	yes
Blurred or double vision	no	yes

☐ **Ears/Nose/Throat/Mouth**

Hearing loss or ringing	no	yes
Earaches or drainage	no	yes
Chronic sinus problems/rhinitis	no	yes
Nose bleeds	no	yes
Mouth sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

☐ **Cardiovascular**

Heart trouble	no	yes
Chest pain or angina pectoris	no	yes
Palpitation	no	yes
Swelling of feet, ankles/hands.	no	yes

☐ **Respiratory**

Persistent cough/throat clearing not associated with a known illness (lasting more than 3 weeks)	no	yes
Spitting up blood	no	yes
Wheezing	no	yes

☐ **Gastrointestinal**

Loss of appetite	no	yes
Change in bowel movement	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Rectal bleeding/blood in stool	no	yes
Abdominal pain	no	yes

☐ **Genitourinary**

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force of strain when urinating	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Male - testicle pain	no	yes
Female - pain with periods	no	yes
Female - vaginal discharge	no	yes
Female – irregular periods	no	yes
Female - # of pregnancies	no	yes
Female - # of miscarriages	no	yes
Female – date of last pap smear	no	yes

☐ **Musculoskeletal**

Joint pain	no	yes
Joint stiffness	no	yes
Weakness of muscles or joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Difficulty walking	no	yes

☐ **Integumentary**

Rash or itching	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes
Varicose veins	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

☐ **Neurological**

Frequent/reoccurring headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness/tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes

☐ **Psychiatric**

Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Insomnia	no	yes
Suicidal thoughts	no	yes
Violent or unusual thoughts	no	yes

☐ **Endocrine**

Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Skin becoming drier	no	yes
Change in hat or glove size	no	yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	no	yes
Bleeding or bruising tendency	no	yes
Anemia	no	yes
Phlebitis	no	yes
Past transfusion	no	yes
Enlarged glands	no	yes

☐ **Allergic/Immunologic**

History of skin reaction or other:		
Penicillin or other antibiotics	no	yes
Morphine, Dermorol or other narcotics	no	yes
Novocain or other anesthetics	no	yes
Aspirin or other pain remedies	no	yes
Tetanus antitoxin or other serums	no	yes
Iodine Methiolate or other antiseptic	no	yes

Other drugs/medications_____
_____
Known food allergies_____
_____
Environmental allergies_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Patient name Date

_____
Signature of Patient/Parent/Guardian

Patient Social History

Marital Status Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Use of Alcohol Never _____ Rarely _____ Moderate _____ Daily _____

Use of Tobacco Never _____ Previously but Quit _____

Use of Drugs Never _____ Type/Frequency _____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Previous Hospitalizations/Surgeries/Serious Illnesses	**When?**	**Hospital/City/State**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription)

_____

_____

_____

_____

_____

Persons to Release Information To:

Name: _____ Relationship: _____

Phone Number: _____

FINANCIAL POLICY

CASH PATIENTS –

Payment in full is due at the time services are rendered. We accept cash, checks, and all major credit cards. If you wish to convert to insurance billing, please refer to the insurance section below and notify this office immediately. _____ **Initial**

INSURANCE –

We submit insurance claims on your behalf. Co-payments are due at the time of each visit. If co-payment is not made, you will be billed. We must have a signed consent from you with the assignment of payments to this office in order to file claims for you. _____ **Initial**

ALL PATIENTS –

You are ultimately responsible for all charges regardless of any existing medical coverage. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Upon discharge from this office, all charges are due and payable within 60 days. A 1½% monthly finance charge _____ **Initial** is added to all amounts after 60 days. This represents an annual percentage rate of 18%. All accounts, upon reaching 90 days past due, are subject to submission to an outside collection agency if satisfactory payment arrangements have not been made with the billing office.

You will be charged $50.00 _____ **Initial** for checks returned from your bank for any reason.

CANCELLED AND NO-SHOW APPOINTMENTS –

This office requires a 24-hour notice if you are unable to keep your scheduled appointment. If we do not receive a 24-hour notice, you will be charged a fee of $50.00 _____ **Initial.**

I, _____, hereby acknowledge that I received a copy of Dr. Richard Uhler's Notice of Privacy Practices (copy below). I have been given the opportunity to ask any questions I have regarding this notice.

If you have any questions or need to make special arrangements for payment, please notify the billing office immediately at (866) 696-0086.

_____ _____

Patient name (print) **Date**

_____

Patient/Parent/Guardian Signature

Treatment with Controlled Medications: Patient Agreement

Pain Treatment with Controlled Medications: Patient Agreement

1, _____, understand and voluntarily agree that
(initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other members of the treatment team.

_____ I will not call between appointments, or at night, or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt care of other patients, my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all of my medicines: _____
Pharmacy name/phone #

_____ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

_____ I will not use illegal drugs such as heroin, cocaine, marajuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

____ I understand with ANY controlled substance, I will need a regular appointment <u>MONTHLY</u>, for any new or refill on prescriptions.

_____ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at _____ are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition.

We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If your become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

_____	_____	_____
Patient signature	Patient name printed	Date
_____	_____	_____
Provider signature	Provider name printed	Date

DR. RICHARD E. UHLER
Notice of Privacy Practices for Protected Health Information

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!

With your consent Dr. Richard Uhler and his staff are permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care options. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Example of Use of Your Health Information for Treatment Purposes:
Treatment information about you is recorded in a health record. During the course of your treatment. The doctor determines a need to consult with another specialist concerning your care. The doctor will share the information with such a specialist and obtain input.

Example of Use of Your Health Information for Payment Purposes:
We submit a request for payment to your health insurance company. The health insurance carrier requests additional information from us regarding the care given. We will provide that information to them about you.

Example of Use of Your Health Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment. quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services. This will be done with all identifying information removed whenever possible; however, on occasion, information about you and your care may be revealed.

Your Health Information Rights
The health record and billing records we maintain are the physical property of the facility. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our center. We're not required to grant the request, but we will comply with any request granted.

- Request that you be allowed to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our center.

- **Law Enforcement-** We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

- **Health Oversight**- Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

- **Judicial/Administrative Proceedings-** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

- **Other Uses-** Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

- **Website**- If we maintain a website that provides information about our entity, this notice will be on the website.

Effective Date: April 14, 2003

I, _____, hereby acknowledge that I have received a copy of Dr.
PRINT YOUR NAME

Richard Uhler's Notice of Privacy Practices. I have been given the opportunity to ask any questions I any have regarding this notice.

_____ _____
NAME **DATE**

PLEASE PLACE SIGNED ORIGINAL IN CHART AND PROVIDE A COPY TO PATIENT

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our center by delivering the written complaint to our Administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is:

Office of Civil Rights - Federal Office Building
US. Department of Health and Human Services
50 United Nations Plaza- Room 322
San Francisco, CA 94102
415-437-8310
www.hhs.gov/ocrhipp8

We cannot, and will not, require you to waive your right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the facility.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

- **Notification**- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member personal representative or other person responsible for your care, about your location and about your condition.

- **Communication with Family-** If you do not objector in an emergency situation, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or regarding payment for such care.

- **Food and Drug Administration (FDA)-** We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

- **Worker's Compensation-** We are not a Workers' Compensation provider and do not accept Worker's Compensation. You will be responsible for all charges associated with your visit.

- **Public Health-** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Abuse & Neglect-** We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

- **Correctional Institutions-** If you are an inmate of a correctional institution, we may disclose your protected health information to the institution, or its agents, as necessary for your health and the health and safety of other individuals.

- Appeal a denial of access to your protected health information, except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our center.
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our center. An accounting will not include internal uses of information for treatment.

payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our center, and
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken, by delivering a written revocation to our center.

If you want to exercise any of the above rights, please contact our facility administrator. in person or in writing during normal business hours. Our administrator will provide you with assistance on the steps to take to exercise you rights.

Dr. Richard E. Uhler
31493 Rancho Pueblo Road Suite 203
Temecula. Ca 92592
Phone: 95 1-693-9678
Fax: 951-302-7710

Our Responsibilities

The facility is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this notice. Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, add or eliminate provisions in our privacy practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our "Notice" or by visiting our center and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Administrator as stated above.