Welcome Letter

Compassionate Family Care would like to take a moment to thank you for choosing our practice as your primary care provider.

We have enclosed a registration form for you to fill out and return to our office. Our staff will review your information and contact you to schedule an appointment. Registration processing times vary depending on availability. Please allow 1-2 weeks for our office to contact you and schedule your new patient appointment.

Please keep in mind our providers set aside time for a new patient consultation: so, we ask if you are not able to make your new patient consultation appointment to contact us within 24 hours to cancel or reschedule. **Habitual missed appointments are grounds for dismissal from the practice and all missed appointments are subject to a missed appointment fee of $80.00 if not properly canceled or rescheduled.**

Please arrive 15 minutes before your appointment time for check in and please bring your detailed list of medications or your medication bottles with you for verification.

Also enclosed you will find a medical records release form. This will give us time to request the records and to allow the other providers office time to send your medical information to us.

All of our patients are required to sign up for the online patient portal. The portal is there for your convenience and allows you to request medication refills, access your medical records, request or schedule future appointments, and communicate directly with our staff or your medical provider.

If you need a medication refill; please contact your pharmacy two days before your medication is due to run out or request a medication refill through the online patient portal. It will take approximately 24 hours from the time the pharmacy has requested authorization to refill your prescription to the time the provider makes a determination. All controlled medications require a monthly visit and must be completed by the providers electronically.

Our office policy states that patients obtaining outside testing will be required to make an appointment with a provider to review those results. **Our providers do not give test results over the phone.**

It is your responsibility to make sure our office has the current insurance carrier information and billing information. If a claim is unsuccessful because of inaccurate insurance or billing information, you will be responsible for the balance.

Co-payments and Co-insurance are due at the time of service and for those patients without insurance we offer a 10 percent discount for service paid in full at the time of visit. If you have insurance, we will bill your insurance carrier. Balances are due within thirty (30) DAYS OF THE BILLING STATEMENT DATE. We will accept payment arrangements which need to be authorized by the billing department within (30) DAYS OF YOUR VISIT. Any balance unpaid after ninety (90) days, without a payment arrangement, will be turned over to a collection agency.

Failure to follow instructions given by the providers will result in dismissal from Compassionate Family Care. This includes releasing yourself from the hospital against medical advice.

We will work hard to accommodate you with the highest quality of care and service possible. If you have any questions, please feel free to contact our office. Again, thank you for choosing Compassionate Family Care.

REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widow	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F Race:	
Street address:		Social Security no.:			Home phone no.: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone no.: ( )	
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.			❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Online	❑ Other		
Primary Language Spoken:						
Current Email:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
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	❑ Key Medical Group	❑ Blue Cross	❑ Medicare	❑ Nationwide	❑ Blue Shield PPO
❑ Health Net	❑ Tri Care	❑ United Health	❑ Foundation For Medical Care	❑ 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.:	Subscriber's Birth date: / /
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 Compassionate Family Care or insurance company to release any information required to process my claims.

Patient/Guardian signature: ***Date:***

COMPASSIONATE FAMILY CARE

MEDICAL HISTORY FORM

Date: _________________

Previous Doctor: _____________________________________**Phone:**___________________

Reason for switching care: ____

____

Patient's Name: ____

Allergies: ____

____

Are you currently taking any medications? Y or N If yes please list them below.

Please list your medications including the strength and how often you take it:

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Medication___________________________**Dosage**________________**Doctor**_______________
Directions____________________________**Reason for taking**____________________________

Patient's Past History: **Mark the boxes to the right either yes or no for the following question: Do you have or have you ever had any of the following:**

	Yes	No
Allergic Rhinitis	( )	( )
Asthma	( )	( )
Cancer/Tumors	( )	( )
Congestive Heart Failure	( )	( )
COPD	( )	( )
Depression	( )	( )
Diabetes	( )	( )
Fibromyalgia	( )	( )
Glaucoma	( )	( )
High Cholesterol	( )	( )
High Blood Pressure (hypertension)	( )	( )
Migraine	( )	( )
Multiple Sclerosis	( )	( )
Myocardial Infarction (heart attack)	( )	( )

	Yes	No
Osteoporosis	( )	( )
Prostate Conditions	( )	( )
Pulmonary Embolism	( )	( )
Seizure Disorder	( )	( )
Sleep Apnea	( )	( )
Stroke	( )	( )
Thyroid Disorder	( )	( )

WOMEN ONLY

Last menstrual period? _____

Birth control? _____

At what age did your menstrual period begin?___

Pregnancy/abortion/miscarriage	( )	( )

Past Surgical History:

List dates of all operations, surgeries, injuries, and illness that required hospitalization:

_____

_____

_____

_____

_____

_____

Family History:

List family members: (mother, father, brothers, sisters, and grandparents, etc) - ages and health status (if deceased write their age at the time of their death and the cause). List allergies and any conditions or diseases they may have or have had, such as asthma, arthritis, tuberculosis, diabetes, cancer, heart disease, hypertension, kidney disease, mental illness, depression, or any other health problems that you know of in your family.

_____

_____

_____

_____

_____

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth:_____

Please mark below if there is a **personal or family history** of any of the following cancers. If yes, then indicate family relationship and **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

Example: Colon Cancer *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs*

BREAST AND OVARIAN CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Breast cancer				
Y	**N**	Ovarian cancer				
Y	**N**	Breast cancer in both breasts OR multiple primary breast cancers				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Uterine (endometrial) cancer				
Y	**N**	Colon cancer				
Y	**N**	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	**N**	10 or more colon polyps found in a lifetime				

MELANOMA:

			You	Siblings / Children	Mother's Side	Father's Side
Y	**N**	Melanoma				
Y	**N**	Pancreatic Cancer				

OTHER CANCERS

		Type of cancer	You	Siblings / Children	Mother's Side	Father's Side
Y	**N**					

For Office Use Only:

Patient offered genetic testing: **ACCEPTED** **DECLINED**

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Patient Authorization of Disclosure of Protected Health Information

Persons Authorized to Disclose Information:
Information listed below will be used or disclosed by:

Name of Record Holder: _____

Address: _____
_____
_____

Health Information to be disclosed:
The information covered by this authorization includes:

( ) Any and all health information including all test results, except as specifically provided below: _____

( ) Other: _____
_____

This health information may be disclosed to:

Compassionate Family Care
306 N. Conyer St.
Visalia, CA. 93291
Phone: (559) 713-1101 Fax: (559) 713-1121

Please Initial:

_____ This authorization is effective now and will remain effective until either:
Indefinitely:_____ Or Expiration Date:_____

_____ I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to receipt.

_____ I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Signed: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

Compassionate Family Care

(559) 713-1101

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:_____

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Consent to Photograph

I consent to be photographed by Dr. Soloniuk-Tays.

Patient Name: _____

Patient Signature: _____Date_____

I refuse to consent to be photographed by Dr. Soloniuk-Tays.

Patient Name:_____

Patient Signature: _____Date:_____

Disclaimer

**The photograph will be taken from the shoulders and above.*

**Patients that refuse to be photographed will not be accepted as patients to Compassionate Family Care. The purpose of the photograph is to provide facial recognition to your sensitive medical records and ensure your privacy.*

TO: PATIENTS OF DR. SOLONIUK-TAYS
RE: **FEE FOR MISSED APPOINTMENTS**
DATE: JANUARY 2022

Unfortunately there are times that Dr. Soloniuk-Tays must charge patients for missed appointments. We are currently scheduling many types of medical appointments several weeks or months in advance due to our increase in patient numbers. When a patient does not keep an appointment or does not call to cancel the appointment within 24 hours prior to the scheduled time, we are denied the opportunity to fill that appointment slot with someone from our waiting list who really does need to be seen.

Dr. Soloniuk-Tays policy of charging for missed appointments, if not notified at least 24 hours in advance, is now referenced in our office, online via the portal or website, and referenced in every appointment reminder message sent. The fee for a missed appointment is $80.00. All appointments canceled less than 24 hours prior to the day of the appointment will incur a $45.00 late cancellation fee. These fees are not covered by your insurance.

Our office will contact you via an automated messaging system, 2 days prior to your appointment date. Our system allows for notifications to be sent via email, voice, or text message. Please let our staff know how you want to be notified. The email or text message option allows you to cancel or request to reschedule your appointment directly.

If you select the voice notification option, please call our office at (559) 713-1101 and advise us if you need to cancel or reschedule your appointment at least one day in advance. If after hours, leave a message with the answering service and the service will give us a message the next business day as to the time and date you called. Your message will also be typed and sent to us ensuring proper delivery of your message.

IT IS VERY IMPORTANT THAT YOU CALL OUR OFFICE AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT TIME TO CANCEL OR RESCHEDULE.

If you have any questions, please don't hesitate to call our office. The number is (559) 713-1101.

_____ _____

Signature **Date**

Gaylene J Soloniuk-Tays MD
306 N Conyer St Visalia, CA 93291
Phone (559) 713-1101 Fax (559) 713-1121

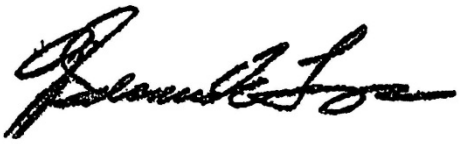
NOTICE REGARDING INAPPROPRIATE BEHAVIOR

As a patient of Compassionate Family Care you have a responsibility to remain respectful when interacting with the physician, nurse practitioners, and staff. Unfortunately there seems to be an unacceptable trend of patients or their family members verbally abusing the office staff.

I have dedicated and hardworking employees who try their best to assure that your medical care and insurance needs are handled in a professional and timely fashion. If you have questions regarding your health care or billing we will do our best to help resolve the issue. Often my staff becomes the target of some individual's anger, which can quickly escalate into abuse.

The intent of this document is to give you prior notice that I will not tolerate abusive or inappropriate behavior of any sort to my staff members or myself. Such behavior will be grounds for immediate termination of our physician/patient relationship and dismissal from my practice. Your signature acknowledges receipt of this information.

Sincerely,



Gaylene J Soloniuk-Tays MD

_____ _____

Patient Signature: **Date:**

Notice of Privacy Practices

Compassionate Family Care
(559) 713-1101

Effective Date: September 01, 2004

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

8. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

9. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

10. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

11. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

12. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

13. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. **Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

You will not be penalized for filing a complaint. Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg. 200 Independence Avenue, S.W. Room 509F HHH Building, Washington,DC 20201