PROMISECARE
Quality Healthcare. Promised.

Hemchand Kolli, M.D.
36243 Inland Valley Drive, Suite 160 Wildomar, CA 92595
(951) 698-8821
https://drkolli.health/

Patient Information

Name:_____ Preferred Name:_____
Last Name First Name MI
Date of Birth: _____ Sex: _____ SSN: _____

Address:_____

City: _____ State: _____ Zip: _____

Preferred Phone #: _____ Secondary Phone #: _____

Email: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D

Demographics (Required by Centers for Medicare/Medicaid Services)

Race:
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific
☐ Decline to specify ☐ White

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Legal Guardian

If the patient is under the age of 18, we need the name of their legal guardian:
Name: _____Cell: _____ DOB: _____

Emergency Contact

Contact Name: _____
Last Name First Name
Relationship to the patient: _____ Phone #: _____

Health Insurance Information

Insurance Name: _____

Name of Insured: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Relationship to Patient: _____ Group # _____

Policy # _____ Copay Amt: $_____ Deductible: $_____
Effective Date: _____ Expiration Date: _____

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Medical History

Patient Name: _____ DOB: _____

Please list your medical problem(s) and how long they have affected you

_____

What is your main symptom?

_____

Check illness or conditions you have had:

☐ Cancer ☐ Asthma ☐ Hepatitis ☐ Diabetes ☐ Glaucoma ☐ Heart Trouble ☐ GERD

☐ Vein Trouble ☐ Emphysema ☐ Nervous Disorder ☐ High Blood Pressure

☐ Bleeding Tendencies ☐ Thyroid Problem ☐ Pneumonia ☐ Kidney Disease

☐ High Cholesterol ☐ Arthritis ☐ Anxiety ☐ Depression

Previous Operations with Dates: ☐ Tonsillectomy Year: _____ ☐ Appendectomy Year: _____

☐ Other Operations and Year: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No Year: _____

When was your last colonoscopy? Year: _____ Who is your GI Specialist? _____

When was your last TB skin test or Chest X-ray? Year: _____

Please list any other illnesses NOT requiring operation for which you were hospitalized:

_____

Have you had serious injuries, broken bones, etc.? ☐ Yes ☐ No List: _____

Current Weight:_____ How long have you been at this weight?_____

Please list any medication allergies:

Medication	Reaction/symptom
_____	_____
_____	_____

Are you allergic to Iodine or Latex? ☐ Yes (CIRCLE Iodine or Latex) ☐ No

List any other medical providers or specialists you see regularly:

_____

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Women

For Women Only: Number of pregnancies:_____ Number of miscarriages:_____

Onset date of last menstrual period:_____ Periods are: ☐ Regular ☐ Irregular

Have you gone through menopause? ☐ Yes ☐ No

Any complications in pregnancies? Please list: _____

Last Mammogram Date: _____ ☐ Normal ☐ Abnormal

Last PAP Smear Date: _____ ☐ Normal ☐ Abnormal

Men

For Men Only: When was your last Prostate Blood Test (PSA)? _____

Immunization History

Your Immunizations: Please check to the immunization shots you have received

☐Tetanus shots Year of last shot: _____

☐Pneumovax Year of last shot: _____

☐Influenza Year of last shot: _____

☐COVID shot(s) Year of last shot: _____

☐COVID booster shot Year of last shot: _____

Pharmacy Information

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

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Cultural History

Education Level:

☐ Elementary ☐ Vocational College

☐ High School ☐ Graduate/Professional

Are there any vision or hearing problems that affect your ability to communicate well? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal) ☐ Yes ☐ No

Occupation: _____

Current Living Situation:

☐ Single Family Household ☐ Shelter

☐ Multi-Generational Household ☐ Skilled Nursing Facility

☐ Homeless ☐ Other

Are there any personal problems or concerns you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

Will you have reliable transportation for all your appointments? ☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Social History

Below are questions regarding your current lifestyle:

Have you traveled outside the US? ☐ Yes ☐ No Where? _____

Have you ever or do you currently smoke or vape? ☐ Yes (CIRCLE smoke or vape) ☐ No

If yes, then:

How many packs per day? _____ How Long? _____ When did you or have you quit? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No How often? _____

Have you ever had same sex relations? ☐ Yes ☐ No How long ago? _____

Have you ever used, or do you currently use illicit drugs? ☐ Yes ☐ No

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If yes, then please describe:

_____

Do you currently use Cannabis products in any form? ☐ Yes ☐ No

If yes, then please describe:

_____

Caffeine intake? ☐ Yes ☐ No

Type: _____ Amount: _____

Exercise routine: _____

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Family History

Alcoholism	☐ Yes	Paternal/Maternal? Who_____	☐ No
Anemia	☐ Yes	Paternal/Maternal? Who_____	☐ No
Allergies	☐ Yes	Paternal/Maternal? Who_____	☐ No
Asthma	☐ Yes	Paternal/Maternal? Who_____	☐ No
Arthritis	☐ Yes	Paternal/Maternal? Who_____	☐ No
Bleeding Disorder	☐ Yes	Paternal/Maternal? Who_____	☐ No
Cancer	☐ Yes	Paternal/Maternal? Who_____	☐ No
Depression	☐ Yes	Paternal/Maternal? Who_____	☐ No
Diabetes	☐ Yes	Paternal/Maternal? Who_____	☐ No
Epilepsy	☐ Yes	Paternal/Maternal? Who_____	☐ No
Glaucoma	☐ Yes	Paternal/Maternal? Who_____	☐ No
Heart Disease	☐ Yes	Paternal/Maternal? Who_____	☐ No
High Cholesterol	☐ Yes	Paternal/Maternal? Who_____	☐ No
Hypertension	☐ Yes	Paternal/Maternal? Who_____	☐ No
Kidney Disease	☐ Yes	Paternal/Maternal? Who_____	☐ No
Mental Illness	☐ Yes	Paternal/Maternal? Who_____	☐ No
Migraines	☐ Yes	Paternal/Maternal? Who_____	☐ No
Obesity	☐ Yes	Paternal/Maternal? Who_____	☐ No
Osteoporosis	☐ Yes	Paternal/Maternal? Who_____	☐ No
Prostate Disease	☐ Yes	Paternal/Maternal? Who_____	☐ No
Stroke	☐ Yes	Paternal/Maternal? Who_____	☐ No
Thyroid Disease	☐ Yes	Paternal/Maternal? Who_____	☐ No
Tuberculosis	☐ Yes	Paternal/Maternal? Who_____	☐ No
Ulcer Disease	☐ Yes	Paternal/Maternal? Who_____	☐ No

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Patient Contact Consent

I _____, hereby give consent to **Hemchand Kolli, M.D.** and his staff to contact me regarding results, referrals, appointments, and any other health issues via:

Check all that may apply

☐**Do not contact anyone other than myself**

☐Cell phone number: _____

☐Answering machine

☐Email address: _____

☐Mail to listed home address

☐Message with spouse/ friend/ caregiver (List Below)

☐Other:

_____	_____
Name	Phone #
_____	_____
Name	Phone #
_____	_____
Patient Signature	Date

HIPAA Compliance Patient Consent

Under the Health Insurance Portability and Accountability Act of 1994 ("HIPAA"), The Family Practice of **Hemchand Kolli, M.D.** does not release confidential medical information regarding your treatment to family members or friends, except for a parent/legal guardian or other persons authorized by the patient.

If you bring another person into the exam room during a regular or emergency appointment, we will assume without objection, the person is entitled to hear or receive information regarding your medical issue and/or treatment.

Notice of Privacy Practice

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA law allows for the use of the information for treatment, payment, or healthcare operations.

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Advance Directive Status

This is acknowledgment that the physician or one of their staff members, has provided and discussed Advance Health Care Directives information with me.

1. I am age 18 or older. ☐ Yes ☐ No

2. I understand I have the option of putting together an Advance Health Care Directive for my healthcare. My physician has provided me written information concerning these Advance Health Care Directives. I understand that it is my responsibility to provide my Physician(s) with any documents that are required to carry out my Advance Health Care Directives.

3. I am aware that Advance Health Care Directives may be any one of the following:

a. A Durable Power of Attorney for Health Care.

b. The Declaration in the A Natural Death Act – For example, A Living Will

c. I may write my wishes on paper so that my family may use the document in deciding my medical treatment in the event I am unable to do so.

Patient's Signature: _____ Date:_____

Provider's Signature: _____ Date:_____

This document will be part of my medical record.

Note: Advance Health Care Directive information is reviewed with the member at least every 5 years and as appropriate to the member's circumstance.

ACKNOWLEDGEMENT

Patient's Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

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Insurance Eligibility Guarantee Form

I, _____, hereby certify that I am eligible for insurance coverage with _____ Health Plan as of __/__/__. I have chosen **Hemchand Kolli, M.D.** to be my primary care physician. I understand that if I am not eligible for coverage with my insurance, I am liable for ALL charges for services rendered. I also understand that it is my responsibility as a patient to notify the office of any changes made with my insurance coverage (co-pay changes, insurance carrier changes, etc.)

1. Private Insurance: This office will bill for all your charges. Please show your insurance card at the window. We ask you to pay any deductible that has not been met, and any co-pay or percentage at the time of your visit. If you have a co-pay or percentage, please remember that payment will be expected at check-in of each visit.
2. Medicare: This office will bill for all your charges. Please show your Medicare card at the window. We ask that you pay any Medicare deductible that has not been met yet and your 20% co-pay at the time of your visit. If you have a secondary insurance, please provide that information to the front desk, so we may bill your secondary, and you will be billed after your visit.
3. PPO/HMO: If you are covered by an insurance company that we are contracted with, please present your card at the front desk. We will bill your insurance after collecting your co-pay at the beginning of your visit.
4. Cash: If you do not have insurance, payment will be expected at the time of your visit. Charges will vary depending on length and extent of your office visit.

NOTE: You will receive a separate bill from the laboratory for all laboratory services ordered (i.e. pap smears, urinalysis, blood work, etc.). These charges are not included in our bill. IF YOUR INSURANCE COMPANY IS CONTRACTED WITH A SPECIFIC LABORATORY, YOU MUST NOTIFY US AT THE TIME OF SERVICE. YOU ARE RESPONSIBLE FOR INFORMING THE NURSE SO THE CORRECT ORDERS CAN BE MADE.

I have read the following information and I understand my financial obligation to the office of **Hemchand Kolli, M.D.**.

_____ _____

Signature of Patient/Guardian Date

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Office Policies

Financial Policies:

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Please ask if you have any questions about the financial policy.

Prescription Policies:

Allow 48-72 hours for All Controlled Medication Refills Monday thru Thursday

- No controlled medication refills will be provided Friday, Saturday or Sunday
- You must call your pharmacy to get a refill for all non-controlled medications
- DO NOT wait until you run out of your medications to contact your pharmacy
- Please call your pharmacy at least one week prior to finishing your medications

Patient Code of Conduct:

Welcome to our practice. Our providers and staff strive to make your healthcare experience the best it can be. We understand that the healthcare system can be confusing and frustrating with your own health concerns. Whether it be refilling prescriptions, specialist referrals, having lab work or x-rays done there can be many moving parts in today's healthcare environment. Please be assured that our staff will do all they can to assist you or accommodate your needs. However, the physicians and staff will not tolerate any of the following:

- Physical or verbal abuse of any kind
- Repeated missed appointments (3 or more No show/canceled appointments)
- Non-compliance of any provider recommended orders including:
    - Not taking medications as prescribed
    - Not having ordered diagnostic studies done (labs, x-rays, or procedures)
    - Non-compliance of our controlled substance agreement

Any of the behaviors listed above may result in you being discharged from this practice due to breach of patient code of conduct. We feel these behaviors compromise the patient/physician relationship and the quality of care we can provide.

We thank you for understanding and welcome you as a patient.

_____ _____

Patient Signature Date

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Appointment Policies

Appointments:

Our hours are by appointments only, but our staff will make every effort to accommodate urgent add on requests.

Late Appointment Arrivals:

Effective March 1, 2011, the office reserves the right to reschedule your appointment if you arrive more than fifteen (or ten according to other forms) minutes late from your scheduled appointment.

I apologize for this inconvenience, but we will be implementing this new policy to provide quality care to all patients in a timely manner.

No Show:

We know that there will be times when you will not be able to keep the appointments that you scheduled. We only ask that if this occurs you call us 24 hours in advance so that we can provide your appointment slot to another patient. If you fail to notify us and fail to keep your appointment, you will be charged a "no show" fee of $25.00. Our practice will be implementing this "No Show" policy to all patients.

I acknowledge that I have read and understood these new policies:

_____ _____

Patient Signature Date