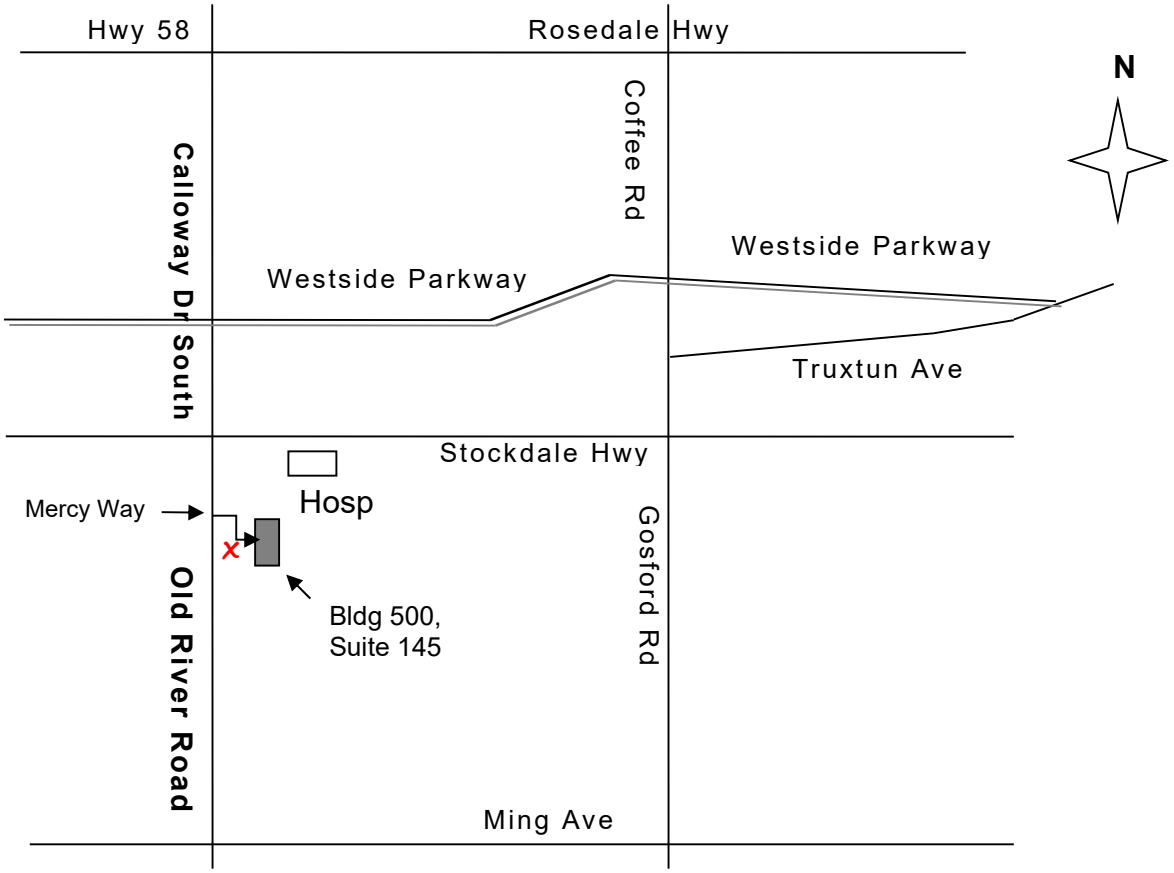
David Bruce Christian, MD

Pamela J. Whiteley, PA-C
500 Old River Road, Suite 145
Bakersfield, CA 93311-9509

(661) 664-0434 Ph
(661) 664-0432 Fax

We look forward to meeting you. Please read ALL of the attached material. Fill out the Patient Health Questionnaire and Signatures of Authorization and Acknowledgment forms. Call us if you need additional instructions. If you can't make your appointment, please give us or our answering service at least 24 hours notice. There is a $50 fine/fee for missed appointments and same-day cancellations.



Best parking is in the West lot adjacent to Old River Rd. There is a side entrance with a small set of steps leading to the door. We are on the ground floor near Hina's Pharmacy. Best disabled parking is on the North side of the building.

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For additional information, visit our website at www.dbchristian.com.

OFFICE & FINANCIAL POLICIES: Please read carefully. Your signature stating that you have read this policy is required prior to any rendered treatment.

PLEASE DO NOT WEAR FRAGRANCES IN THIS OFFICE

We have patients and staff members who are extremely sensitive to some fragrances, which cause nausea, vomiting, migraine headaches and respiratory difficulty. Please refrain from wearing perfumes, colognes, body sprays, or other scented products to your appointment.

We are a small private medical practice with one Physician and one Physician Assistant. We accept most major PPO insurance plans and are contracted with Bakersfield Family Medical Center HMO.
We treat patients ages 7 and up. Written parental consent is required by law if the minor is not accompanied by a qualifying parent or guardian.
We do not treat work or motor vehicle injuries or perform employment physicals.

We reserve the right to charge $50.00 for missed appointments and same-day cancellations.
If you are more than 10 minutes late to your scheduled appointment, you might be asked to reschedule. If you are unable to keep your appointment, please notify our office staff at least 24 hours in advance or ASAP. You may leave a message with the answering service after normal business hours. If you miss two New Patient appointments, you will not be allowed to establish care here.

In the event you are seen by another physician at an Urgent Care, Emergency Room, or Hospital, we require those medical reports prior to scheduling a follow-up visit with Dr. Christian or PA Whiteley. Please sign a release of medical information at the time of service.

WE DO NOT ACCEPT NEW CASH PATIENTS

INSURED PATIENTS are responsible for providing us with complete and current insurance information. If we are unable to verify or validate your insurance prior to the time of service, you will be rescheduled. If you are double-covered, please indicate which plan is your primary coverage and which is your secondary coverage. Incorrect information can result in claim payment delays. For families with dual insurance coverage, a birthday rule applies. The birthdate of the parent that falls first in the year becomes primary for dependents.

You are responsible for your co-payment at check-in. If you do not have it, your appointment will be rescheduled. You will be notified via paper statement for any balances due after the claim has been processed. These balances are due upon receipt of the statement. Unpaid balances are grounds for dismissal.

You are ultimately responsible for all costs related to services provided here. We accept cash, checks, VISA or MasterCard for co-payments, co-insurance and deductibles.

We take checks as a courtesy to our patients. If a check is returned from the bank for non-sufficient funds, we will notify you via mailed statement. Along with a $30 fine, if the balance is not paid within 30 days, it will be turned over to our collection agency.

DELINQUENT ACCOUNTS: Our office mails statements to collect on past due balances. Unpaid balances will be turned over to our collection agency, Commercial Trade Bureau. CTB assesses interest on your past due balance. If you have questions about your statement, please call us sooner rather than later. Anyone sent to collections for any reason or amount is automatically discharged from our practice.

FORM FEE: There is a $30.00 fee for some forms that need to be completed and/or signed by the physician or office staff. Please fill out and sign your portion of the form before presenting it to us.

MEDICAL RECORD COPY FEE: There is no charge for transferring records to another physician for continuation of care. If you want a personal copy of your medical chart, you will be assessed a $30.00 fee.

DON'T RUN OUT of your medications!
Please monitor your medications and contact us in advance when you are running low*. Depending on your treatment plan, you might be required to schedule a follow-up appointment before the medication refill will be authorized. We recommend that you call our office to process requests for prescription refills even if your pharmacy tells you that they have contacted us. Remember that other patients have similar requests of our staff throughout the day.

*Mail order pharmacies have a 10-day to 2-week turn-around time.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW IT CAREFULLY.***

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, however, we are not required to agree to your request for restrictions.
- Inspect and obtain a copy of your health records, except in limited circumstances upon written request. A $30 fee will be charged to copy your record. We will use the format you request unless it is not practical for us to do so.

If you are denied access to your health record for certain reasons, we will tell you why and what your rights are to challenge that denial.

- Amend your health record. Your request must be in writing and state a reason. If we deny your request, we will tell you why and what your rights are to challenge that denial. Even if we accept your request, we will not delete any information already in our records. You have the right to add an addendum (up to 250 words) to your health record.
- Obtain an accounting of disclosures of your health information for purpose other than treatment, payment or health care operations, disclosures to you or authorized by you, incidental disclosures and certain other excluded disclosures. Your request must be in writing.
- Request confidential communications of your health information by alternative means or at alternative locations.
- Revoke authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- abide by the terms of this notice currently in effect.
- notify you if we are unable to agree to a requested restriction.
- accommodate reasonable requests you may have to communicate health information confidentially by alternative means or at alternative locations.
- not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosure for Treatment, Payment and Health Care Operations :

- ***We will use and disclose your health information for treatment.***

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record. Your physician will document in your record his or her expectations. We may disclose your health information to ancillary or specialty care services that may be requested by your physician for treatment. Those providers will record their care in their records and copy your physician on their observations. In that way, you will be provided treatment and your physician will know how you are responding to treatment.

- ***We will use and disclose your health information for payment/encounter data.***

For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used and your treatment for which payment is requested. We may also disclose your health information for one of your other health care providers to submit requests for payment.

- ***We will use and disclose your health information for our health care operations.***

For example: Members of the medical staff and the risk or quality improvement team of this practice may use information in your health record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

- ***We will use and disclose your health information for health care operations of others.***

For example: We may disclose your health information to other health care providers or payers for their health care operations only if they already have a relationship with you and the purpose is for quality assurance activities, peer review activities, detecting fraud, or other limited purposes.

EXAMPLES:

Appointment Reminders: We may use and disclose medical information for purposes of reminding you of your appointments.

Involvement in your care: We may disclose information to individuals involved in your care or to individuals who pay or help pay for your care.

Abuse, neglect or domestic violence: We may disclose information for reporting abuse, neglect or domestic violence to a government authority, including a social service or protective services agency as authorized by law.

Health oversight activities: We may disclose health information to a health oversight agency for oversight activities authorized by law.

Judicial and administrative proceedings: We may disclose health information in the course of any judicial or administrative proceeding.

Serious threat to health or safety: We may disclose health information to prevent a serious threat to the health or safety of another.

Specialized government functions: We may disclose health information required by command authorities for military and Veterans.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

National Security and intelligence activities: We may disclose health information for National Security and intelligence activities.

Genetic Testing Information: If we keep genetic testing information about you, we will release that information only to the state departments that monitor our work or if required by law to release that information. Otherwise, we will give out this information only if you give us your permission in writing.

Communicable Disease Information: If you have a communicable disease, such as HIV/AIDS, we will provide that information to your health care provider, to providers engaged in organ procurement, or if required by law. For all other purposes, we will give out this information only with your permission.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Director, Coroner, Medical Examiner, Organ Procurement Organization: We may disclose health information to help these parties carry out their duties consistent with applicable law.

Patient Education: We may contact you to provide appointment reminder or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Workers Compensation/Third Party Liability: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or third-party payers or other similar programs established by law.

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

Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health safety of other individuals.

Law Enforcement : We may disclose health information for law enforcement purposes as required by law We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post those changes in our office and on our website: www.dbchristian.com.

Notice of Change to Privacy Practices:

We have the right the change our privacy practices and terms of this notice at any time, provided that the changes are permitted by law. We have the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information preciously created or received before the change. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

For More Information, Report a Problem, or to exercise your rights - You may contact the Office Manager at (661) 664-0434. There will be no retaliation for filing a complaint. You may also contact the Secretary of the Department of Health and Human Services, Office of Civil Rights, San Francisco Office, U.S. Department of Education, Old Federal Building, 50 United Nations, San Francisco, CA, 94102-4102.

PATIENT HEALTH QUESTIONNAIRE

Patient name (please print)	Date of Birth	Patient Signature	Appointment Date
_____	____/____/____	_____	____/____/_____

State the **MAIN** reason for your visit today:_____

If you see any specialists, please list them:_____

*As you review the following list, please **check** any problems or conditions that you have or have had.*

- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Bleeding disorder
- ❑ Blood Transfusions
- ❑ Cataracts
- ❑ Diabetes ❑type 1 ❑ type 2
- ❑ Asthma/COPD/Emphysema
- ❑ Epilepsy / Seizures
- ❑ Female: # miscarriages ____
- ❑ Female: # pregnancies ____
- ❑ Female: Abnormal Mammogram
- ❑ Female: Abnormal Pap smear
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart Attack
- ❑ Heart Issues
- ❑ Hepatitis C
- ❑ High blood pressure
- ❑ Kidney Stones
- ❑ Lupus
- ❑ Male: prostate problems
- ❑ Menopause
- ❑ Migraines
- ❑ Mini stroke/ TIA
- ❑ Multiple Sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Paralysis
- ❑ Rheumatoid Arthritis
- ❑ Seasonal Allergies
- ❑ Skin Cancer
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Valley Fever
- ❑ Other _____

_____

_____

_____

Surgeries:	Year		Year
Tonsils Removed		Vasectomy	
Appendix Removed		Knee L / R	
Gallbladder Removed		Shoulder L / R	
Uterus Removed		Hip L / R	
Ovaries Removed		Back	
Prostate Removed		Other:	
Gastric Bypass/Sleeve			
Heart Bypass			
Heart stent placed			

Family Medical History of Mom, Dad, Brother, Sister (ONLY):	Which member?
Aneurysm	
Diabetes	
Heart Attack /Heart Disease	
High Blood Pressure	
Stroke	
Cancer (type)	
Other:	

Risk Factors	What type? *(or "none")*	How much?	How often?	Quit date?
Alcohol				
Nicotine/Tobacco				
Caffeine				
Recreational drugs				
Exercise				

Medications you currently use:	Strength:	How many at once?	AM	PM	Other

❑ **I have no known allergies to medications**.

❑ **I am allergic to the following medications:**

_____ Reaction:_____

_____ Reaction:_____

_____ Reaction:_____

Please BRING your current medication bottles with you to your first appointment. Use a clear zip-loc bag.

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Signatures of Authorization and Acknowledgement

Patient's Name (please print) _____ Date of Birth (mm/dd/yyyy) _____

Personal Representative or Responsible Party (please print) _____ Relationship to Patient _____
(i.e. parent, legal guardian, healthcare surrogate, or other)

I have received a copy and have had the opportunity to review both Dr. Christian's Financial Policy brochure and "Notice of Privacy Practices" brochure.

I understand that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision regarding reimbursement made by my insurance carrier.

I authorize payment of the medical and/or surgical benefits, if any, to Dr. Christian.

I authorize to Dr. Christian to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier.

Effective Jan. 1, 2023 a new law requires us to provide a written notice about the Open Payments Database : "For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public." "The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

Signature of patient or other responsible party _____ Date Signed (mm/dd/yyyy) _____

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Authorization to Release Medical Information to Spouse/Other:

I, _____, hereby authorize the
(Patient's Name)
release of any and all medical information concerning my diagnosis and treatment to:

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

Your signature below will remain in effect until _____,
(list a future date) or (forever)*

unless written consent is received to revoke your authorization.

***Expiration date REQUIRED for this form to be valid.**

_____ _____

Signature of Patient Date Signed (mm/dd/yyyy)

MEDICAL RECORDS REQUEST

I hereby authorize the use and disclosure of protected health information from:

Doctor's Name:_____ Phone:_____
Address:_____ Fax:_____

to be furnished to **David Bruce Christian, M.D.** via paper, secure fax, or CD-ROM (**PDF** files only)**:**

at: 500 Old River Road, Suite 145 (661) 664-0434 Phone
Bakersfield, CA 93311-9509 (661) 664-0432 Fax
claire@dbchristian.com

Information requested for the purpose of: ☐ **Healthcare** ☐ Insurance Coverage
☐ Personal ☐ Other: _____

Please *initial* next to the category of information you wish to have released to us:

initial All of my health information pertaining to any medical history, physical condition and treatment received.
initial All records for the last 2 years
initial Last Progress Note(s)
initial Radiology/Imaging Reports
initial Consultation Reports
initial Laboratory/Pathology Reports
initial Other Medical records relating to injury

Disclosures requiring special consent: My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosing, or treatment for *(initial applicable headings):*

initial HIV/AIDS virus
initial Drug / Alcohol Abuse Treatment
initial Mental Health / Psychiatric Disorders
initial Sexually Transmitted Disease

This authorization will expire on: _____date required_____.
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. Imay inspect or obtain a copy of any information to be used and/or disclosed under this authorization inaccordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this information.

Please fill in the box below

Patient Name: _____
Address: _____
City: _____ State:_____ ZIP: _____
Birthdate: _____/_____/_____ Phone: _____
Social Security #: _____-_____ - _____ Maiden/Other Name: _____

_____ _____
Signature of Patient or Responsible Party Date

Complete this form only if you have an HMO plan with Bakersfield Family Medical Center/Heritage Physician Network

Advance Directive Information

Bakersfield Family Medical Center/Heritage Physician Network (BFMC/HPN) members are advised of their right to make health care decisions and to execute Advance Directives. California's **PSDA** Patient Self Determination Act law effective 12-1-91 allows individuals to direct their own care.

What is an Advance Health Care Directive?

An Advance Health Care Directive asserts an individual's rights to accept or refuse treatment and gives direction to those close to the patient and to their medical providers.

An Advance Health Care Directive is a document that may authorize another person to make health care decisions for a patient when the patient is no longer able to make decisions for him or herself.

An Advance Health Care Directive may contain information about a patient's desires concerning end-of-life health care decisions such as organ donation, pain management, and life support.

Would you like to ensure that the health care you might receive at a time when you are unable to speak for yourself, would be what you really desire?

PLEASE READ AND RESPOND TO THE FOLLOWING STATEMENTS

1. I would like more information about advance directives and my right to accept or refuse medical treatments.* Yes ☐ No ☐

2. I have already executed a Durable Power of Attorney or an advance directive for health care. Yes ☐ No ☐

3. I understand that I am not required to have an advance directive in order to receive medical treatment at the healthcare facility. _____(Please Initial)

Name: _____ Date of Birth:_____
(Please Print Clearly)

Signed:_____ Today's Date:_____

*Address where BFMC can send you more information:

_____
Street Apt #

_____
City State Zipcode

***** Staff: Please fax a copy to Cindy at BFMC-Health Education Department (661) 846-4658.