Shawn A. Allen, MD

79430 Hwy 111 Ste. 101
La Quinta, CA 92253
Phone (760) 564-3533 Fax (760) 564-3360

Patient Name: _____ Today's Date:_____
First Middle Last

Sex: M☐ F☐ U☐ Date of Birth: ____/____/_____ Marital Status: S☐ M☐ D☐ W☐

Address: _____ Email Address: _____
Mailing Address City State/Zip

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

SSN: _____ Ethnicity/Race: _____

Employer: _____ Ph: (_____) _____ - _____

Emergency Contact: _____ Ph: (_____) _____ - _____

Pharmacy: _____ Ph: (_____) _____ - _____

If Patient is a Minor, _____ Ph: (_____) _____ - _____

Responsible Party:

Relationship to Patient: _____

PRIMARY INSURANCE (We will take a copy of your card)

Subscriber Name: _____ Date of Birth: ____/____/_____

Relationship to Patient: Self Spouse Parent Other

Insurance Co: _____ Subscriber #: _____

SECONDARY INSURANCE

Subscriber Name: _____ Date of Birth: ____/____/_____

Relationship to Patient: Self Spouse Parent Other

Insurance Co: _____ Subscriber #: _____

RELEASE OF BENEFITS

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan. to issue payment check(s) directly to Dr. Shawn A. Allen for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance in accordance with my insurance guidelines.

Signature: _____ Date: ____/____/_____

Name: _____ Date of Birth: ____/____/_____

Family History Please see Separate Sheet for Hereditary Cancer Syndromes		
Family Member	**Illness**	**Living/Deceased**

I was adopted and do not know my family history:

Social History			
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			
Highest Level of Education: _____			
Employer & Job Title: _____			
Race: ☐ Caucasian ☐ Hispanic American ☐ Asian American ☐ Native American ☐ Other			
Do you smoke:	☐ Yes ☐ No	If yes, how many packs per day? ____	For how long? _____
Have you ever smoked?	☐ Yes ☐ No	If yes, how many packs per day? ____	For how long? _____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how many drinks per week? _____	
Do you use illegal drugs?	☐ Yes ☐ No	If yes, which ones? _____	
Do you use medical marijuana?	☐ Yes ☐ No	If yes, how much? _____	
Do you have a history of Drug or Alcohol abuse?		☐ Yes ☐ No	

Review of Systems Please check next to any conditions you have had or have currently		
Constitutional: Weight Change ☐	ENT: Mouth Ulcers ☐	GI: Nausea/vomiting ☐
- Fatigue ☐	- Upper respiratory infection ☐	- Diarrhea ☐
Eyes: Vision Changes ☐	Cardiovascular: Chest Pain ☐	- Bloody stools ☐
- Cataracts ☐	- Difficulty breathing when lying down ☐	- Constipation ☐
- Glaucoma ☐	- Difficulty breathing on exertion ☐	Psychiatric: Depression ☐
Musculoskeletal: Weakness ☐	Hematologic: Easy Bruising ☐	- Anxiety ☐
Skin: Rash ☐	- Easy bleeding (gums or nose bleeds) ☐	Endocrine: Hot Flashes ☐
Neurological: Seizure ☐	- Adenopathy (swollen glands) ☐	- Diabetes ☐
- Syncope (fainting) ☐	Immunological: Seasonal Allergies ☐	- Thyroid Problems ☐
- Headache ☐	- Food Allergies ☐	Respiratory: Short of Breat ☐

Name: _____ Date of Birth: ____/____/_____

Medical History		
Medical Problems List:	**Name of Medication:**	**Dose:**

Allergies	
Name of Medication:	**Reaction:**

Surgical and Hospitalization History		
Date:	**Surgery, Serious Injuries or Reason for Hospitalization:**	**Comments:**

Advance Directive Acknowledgment

(Durable Power of Attorney for Health Care Declaration)

Information provided by: _____ (Name and relationship to Patient)

☐ The Patient has an Advance Directive and has supplied _____ with a copy of the document. This copy of the Advance Directive has been placed in the patient's medical record.

☐ The patient acknowledges he/she has an Advance Directive and a designated person will bring a copy for the patients' medical records.

- Check One:
  - ☐ Durable Power of Attorney for Health Care
  - ☐ Living Will
  - ☐ Directive to Physicians

☐ The patient is from a licensed care facility and the Admitting Department Staff has verified that the facility has forwarded any Advance Directive documentation to _____.

☐ The Patient does not have an Advance Directive and has been given a copy of the Durable Power of Attorney for Health Care Decision should the patient choose to execute an Advance Directive

☐ The Patient does not have an Advance Directive and would not like to receive a copy of the Durable power of Attorney for Health Care Decisions.

Signature Patient/Representative of Patient: _____ Date: ____/____/_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO
INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or the staff of Dr. Shawn A. Allen other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

☐ I do not authorize Dr. Shawn A. Allen to release any or all information concerning my medical care to any individual except as set for above.

☐ I do authorize Dr. Shawn A. Allen to verbally release any or all information concerning any medical care to the following individuals:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature: _____ Date: ____/____/_____

Print Name: _____ DOB: ____/____/_____

This release will remain in effect until rescinded/revised in writing by the patient.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize treatment, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment at Dr. Shawn A. Allen, Inc

Signature of Patient/Parent if Minor:_____ Date ____/____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. Shawn A. Allen reserves the right to modify the privacy practices outlined in the notice.
Copy of Privacy Practices are posted in waiting room copy available upon request

Name of Patient:(Please Print) _____ Date: ____/____/_____

Signature of Patient/Parent if Minor:_____ Date ____/____/_____

Financial Policy and Insurance Information

I understand and agree that insurance claim forms will be submitted to my insurance company but that I am ultimately responsible for all charges regardless of my existing medical coverage. I hereby give authorization for payment of insurance benefits to be made directly to Dr. Shawn A. Allen for services rendered. In the event that my insurance company forwards payment directly to me, instead of Dr. Shawn A. Allen, I will immediately deliver said payment to Dr. Shawn A. Allen. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due, upon demand. I understand and agree that if it becomes necessary for Dr. Shawn A. Allen to utilize an outside collection agency or to commence court action, for the collection of any outstanding charges, I will be responsible for the outstanding balance (plus a $35 processing fee), and in addition, attorney fees, court costs and other expenses of litigation.

Co-Payments

Due to contractual obligations with your insurance company, all co-payments will be collected at the time of service. Co-payments are not billable, and collection of co-payments are non-negotiable.

Completion of Forms

There is a charge for completing forms such as disability forms, DMV forms, or employer forms for various leaves. The Form Fee varies depending on the type of form; however, the minimum fee is $25. The fee for this service is payable in advance of completing the forms. Please allow 5-7 business days for completion of any form.

Dr. Allen's Office Policy

I have received a copy of Dr. Allen's Office Policies and have a clear understanding of these policies and expectations. I read the no show/excessive cancellation portion and understand that if I no show to 3 appointments that our doctor patient relationship will end and I will have to obtain a new physician.
I have reviewed and understand the above stated policies as indicated by my signature. By signing below, I am also stating that I am the person responsible for charges.

Signature of Patient/Parent if Minor:_____ Date ____/____/_____

Office Policies

We are glad that you want to become a patient of Dr. Shawn Allen's. New patients are always welcome here. Everyone at Dr. Allen's office is committed to making your visits pleasant and stress-free. You can count on our friendly staff to always provide the highest standard of care.

Financial Information

Co-pays, co-insurance and deductibles are due at the time of services are rendered. We accept credit card, cash, and checks. If you are unable to pay your patient responsibility, then your appointment may be rescheduled to our next available appointment.

Dr. Allen uses an outside billing provider so any inquiries about past due balances, payments, or general billing issues, you may contact our Medical Billing Department at 760-863-1592.

Appointments

Any patient arriving more than 15 minutes late for their appointment will be rescheduled to our next available appointment.

Appointments that are not cancelled within 24 hours are subject to a $25.00 non-cancellation fee that will need to be paid in full before scheduling another appointment.

Appointment reminders are sent via text and email 1 week and 1 day prior to your scheduled appointment. No phone calls are made for appointment reminding. Please advise staff which method you prefer or ask for an appointment card.

Patient Testing Protocols

Our patient protocol will help you know what to do when Dr. Allen has ordered lab work or radiology testing for you.

A mailer with results will be mailed to your home. All abnormal testing that needs immediate addressing, you will be contacted by a medical assistant or physician. Results may take up to 10 business days.

Disability Forms / Medical Records

1. There is a $25.00 charge to fill out and mail/electronically submit disability/FMLA forms and a $25.00 charge to gather medical records for personal use. Any records forwarded to another physician for continuation of care will be sent to the new/additional physician's office at no charge.
2. All disability/ FMLA forms completion requires a 5-7 business day window from the time delivered to our office. Due to the high volume of requests we cannot accommodate the immediate completion of any such forms.

Pharmacy Refills/ Referrals/Messages

1. Pharmacy Refills: Please do not wait until the last minute to request refills as we have a 48-hour window to complete refill requests. If you need a refill check with your pharmacy first as you may have refills on file. If you do not, ask your pharmacy to contact us for a refill. They will fax us the request. No refills will be given to patients that have not been seen within a year. Refills for mail order prescriptions should be called to our office and a written prescription will be prepared within 48 hours. We do not mail these prescriptions to patients.
2. Referrals: Please allow 10 business days for referrals to be submitted and processed. Urgent referrals are processed anywhere from 1-3 business days depending on the insurance plan. Desert Oasis patients may call 760-320-5134 to check the status of the referral at any time.
3. Messages: Your calls are important to us. Any messages left with our office staff will be forwarded to the physician. You will be asked to provide the reason for your call, your full name, date of birth and a good call back number. The physician will determine whether she or a trusted member of the staff returns your call depending on the nature of the request.

No Show/ Excessive Cancellation Policy

Dr. Allen carefully schedules appointments to afford quality care for each of our patients. When you miss or change your appointment without any advanced notice, the time we created for you cannot readily be given to someone else who may need it. We ask that if you must change an appointment, please give us a minimum of 24-48 hours advance notice. When you do this, we may be able to schedule someone on our waiting list. Remember too, that when you postpone recommended care you jeopardize your own health. So, it helps you and us when you keep your appointments. We do enforce a $25.00 no show fee for missed appointments with no advanced cancellation/ reschedule.

- Three (3) appointment no call/ no show will result in Dr. Allen discontinuing her physician-patient relationship with you and a certified letter will be sent explaining that you will need to find another physician for your care. **