2025 NEW PATIENT PACKET

DAWES FAMILY MEDICINE- THOMAS M DAWES, JR MD- A MEDICAL CORPORATION
116 S PALISADE, STE 210 SANTA MARIA CA 93454 PHONE (805) 934-2488 FAX (805) 934-2480

Patient's Last Name:	First Name:	Middle:	Marital Status: [] Single [] Married []Partnered [] Divorced [] Widowed [] Separated
Birth date: / /	Age:	Sex: [] M [] F	Email:
Physical Address:	City, State, Zip:		
Mailing Address: ___ check if same as above	City, State, Zip:		
Home Phone: ( )	Work Phone: ( )	Mobile Phone: ( )	Ok to leave voice message on: [ ] Home# [ ] Work# [ ] Cell#
Occupation:	Employer:	[] check if Student Where?	
Social Security #:	Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Decline to Answer		
For patient under 18 years of age:	Lives with: [ ] Mother Name: Phone: [ ] Father Name: Phone: [ ] Guardian Name: Phone:		
Race:	[ ] Alaskan Native or American Indian [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] White [ ] Unknown [ ] Other _____ [ ] Decline to Answer		

INSURANCE INFORMATION:
Current Insurance Cards Are Required at Time of Service to Verify Eligibility

PRIMARY INSURANCE	SECONDARY INSURANCE	
Insurance Company:	Insurance Company:	
Insurance Type: [] HMO [] PPO [] MEDICARE [] OTHER:	Insurance Type: [] HMO [] PPO [] MEDICARE [] OTHER:	
Subscriber's Name:	Subscriber's Name:	
Subscriber Birthdate: / /	Subscriber Birthdate: / /	
Patients relationship to subscriber: [] Self [] Spouse [] Child [] Other:	Patients relationship to subscriber: [] Self [] Spouse [] Child [] Other:	
Person responsible for bill (if different from patient):	SS#:	Address (if different):
Home Phone: ( )	Employer:	Work Phone: ( )

IN CASE OF EMERGENCY:			
Name of Emergency Contact:	Relationship to Patient:	Phone: ( )	Phone: ( )
PREFERRED PHARMACY:			
Local Pharmacy Name:	Street/Intersection:	City:	Phone # if known:
Mail Order Pharmacy (if used):			

Office/Financial Policies

Dawes Family Medicine is pleased that you chose our team to help with your healthcare needs. We feel that part of good healthcare practice is to establish and communicate our office and financial policies with our patients.

Please read this document in its entirety and sign prior to your office visit. You will be asked to fill out this patient information form at your initial visit and **each year thereafter**. Be sure to inform us of any changes of information such as insurance, address, telephone number and employer when they occur.

Per calendar year, our office charges an annual fee for our Customized Care Program. This fee helps cover the expenses incurred by the office on your behalf that are not reimbursed by insurance carriers. Insurance does not cover and/or reimburse the annual fee.

C U S T O M I Z E D C A R E P R O G R A M

2025 ANNUAL OFFICE FEE:

$150 per Member

With the Customized Care Program, you will continue to receive Specialty Care Coordination – Dr. Dawes. Dianne Dawes, PA-C, Amanda Weir, FNP-C and Tiffany Quinn, NP who have developed relationships for the past 20 years with the top specialists on the central coast!

And all the following:

- More appointment availability, both in-office and through Telehealth
- No additional charge for most forms (unless it is a complicated one such as FMLA and Disability or Board and Care Forms)
- Home Care Coordination
- Enhanced safety protocols for Covid-19 (Medical Compliance to aid in supporting patient safety)
- Expanded Telemedicine Services through our HIPPA compliant software
- Remote Patient Monitoring

INSURANCE: Our office contracts with many insurance companies and plans. Your insurance company provides you with proof of insurance, ***which must be present at each visit to check for eligibility***. If proof of insurance is not presented, or if you declared PCP is not affiliated with Dawes Family Medicine, your account will be considered a cash account with full payment expected at time of service.

If we are contracted as preferred providers with your health plan, we will bill your insurance company directly. If we are **not** contracted providers with your insurance company, we expect payment in full at the time of service. We will be happy to provide you with the information you need to bill your insurance company for any eligible reimbursement.

Your individual insurance plan is an agreement between **you and your insurance company**. Medical offices do not know what medications, procedures, medical facilities and specialists are covered under your plan. Therefore**, it is necessary for you to know the specific details of your own plan. It is especially important for you to notify us if there are restrictions regarding referrals for services by outside facilities or providers. You may be responsible for charges from those outside providers if they are not preferred providers with your insurance company and/or you have not received the proper authorization prior to receiving services.**

PRIOR-AUTHORIZATIONS: As part of our Customized Care Plan, we work extremely hard to try and obtain prior authorization on your behalf from your insurance company. Our providers order tests and recommend procedures when medically indicated- independent of any insurance company or outside medical opinion. Even when a prior authorization has been secured, no guarantee is given by the Insurance Company for payment. There have been some instances where the Insurance Company is denying payment after the treatment and/or procedure has been performed. The patient is ultimately responsible for any services rendered.

CO-PAYS, NON-COVERED BENEFITS, AND PATIENT BALANCES ARE DUE AT THE TIME OF YOUR VISIT: For your convenience, we accept cash, check, and credit cards. Insurance is billed as a courtesy and the benefits are authorized to be paid directly to the Practice.

PATIENTS ARE RESPONSIBLE FOR THE BALANCE IN FULL IF NOT PAID BY THE INSURANCE COMPANY. If the patient is not prepared to pay the co-pay or balance due, a member of the clinical staff will determine if it is medically necessary for the patient to see the provider. If the patient's condition allows, the appointment will be rescheduled.

PATIENT BALANCE: Patient balances over 60 days past due from the statement date may be sent to collections if arrangements are not made with the billing department. Failure to pay your patient balance after 3 statements have been sent could result in a discharge from the practice. Please call the billing department at 934-2488 x105 if you have any questions and/or to discuss necessary arrangements.

RETURNED CHECKS: There is a $30.00 fee for returned checks.

FAILED APPTS AND APPTS CANCELED LESS THAN 24 HRS IN ADVANCE: Minimum fee of $100.00 for 1st no-show, $150 for 2nd no-show, and 3rd no-show $200 and you will be discharged from the practice.

ALL THIRD-PARTY BILLING/MOTOR VEHICLE ACCIDENTS: There is a $250 fee for all motor vehicle accident appointments; we can provide you with the required medical notes to file your claim.

WORKERS COMPENSATION: We do not see work-related injuries. You must see the Workers Compensation health care provider that your employer policy is affiliated with.

By signing my name below, I certify that I have read this document. Any questions concerning these policies have been discussed. My signature also certifies my understanding of, and agreement with the Dawes Family Medicine Office Policies.

- **I verify that I am fully responsible for the fees and medical services provided by Dawes Family Medicine.**
- **In the event that medical services provided by Dawes Family Medicine are deemed ineligible by my insurance, I am responsible for the full cost of the services.**
- **I understand that my balance is due and agree to pay in full any balance within 45 days of the statement date.**
- **I understand that charges on my account are deemed correct unless I notify the billing manager within 30 days.**
- **I understand that patient balances over 60 days past due from statement date may be sent for collections if arrangements have not been made with the billing manager.**
- **I understand that the Customized Care Program fee is due annually and is not covered by insurance.**

_____ _____

PATIENT (OR GUARDIAN) SIGNATURE **DATE**

_____

PRINT NAME

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Dawes Family Medicine – A Medical Corporation for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for the medical practice. I understand that diagnosis or treatment of me by Dawes Family Medicine
– A Medical Corporation may be conditioned upon my consent evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the medical practice. Dawes Family Medicine – A Medical Corporation, is not required to agree to the restrictions that I may request. However, if the medical practice agrees to a restriction I request, the restriction is binding on Dawes Family Medicine – A Medical Corporation and employees.

I have the right to revoke this consent, in writing, at any time except to the extent that Dawes Family Medicine – A Medical Corporation has taken action in reliance of this consent. Otherwise, this consent is valid for a period not to exceed 6 years from the date signed.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have the right to review Dawes Family Medicine – A Medical Corporation Notice of Privacy Practices prior to signing this document. The medical practice's Notice of Privacy Practices will be provided to me to review, if requested. The Notice of Privacy Practices describes in more detail the types if uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Dawes Family Medicine – A Medical Corporation. The Notice of Privacy Practices for Dawes Family Medicine – A Medical Corporation is also posted in the medical office waiting area. The Notice of Privacy Practices also describes my rights and Dawes Family Medicine – A Medical Corporation with respect to my protected health information.

Dawes Family Medicine – A Medical Corporation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Any questions regarding this document or the Notice of Privacy Practices should be directed to our Privacy Officer• Jennifer Zepeda at (805) 924-2488 or by email at jzepeda@dawesfamilymedicine.com.

PATIENT OR REPRESENTATIVE SIGNATURE	PATIENT OR REPRESENTATIVE PRINTED NAME:	DATE:
DESCRIPTION OF REPRESENTATIVE'S AUTHORITY REQUESTED □ RESTRICTION REQUESTED □NO RESTRICTIONS		
SIGNATURE OF DAWES FAMILY MEDICINE EMPLOYEE:		

Tele-Office Medical Appointment CONSENT

Dawes Family Medicine is pleased to offer a new type of medical appointment using updated technology to make more appointments available at our office. We have found that some of the services we provide require expert care and knowledge but don't always need the physical presence of a provider. Such things include updating medications, some routine refills, lab review, and Medicare Wellness Evaluations. Today you are being given the opportunity to participate in this new venture called **Telemedicine.**

CA State Law Telemedicine/Telehealth Definition "Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." **Source:** *CA Business & Professions Code Sec. 2290.5*.

We are providing a way for you to meet with a health care provider remotely via a HIPAA secure video conferencing network. We will provide technology and assistive devices such as headphones for the hearing impaired. Please be aware that the appointment is limited in scope - it is not for assessing medical emergencies nor can we discuss issues that you were not scheduled for. If the provider feels that a more detailed exam is needed you will be rescheduled for an appointment with a clinician in office.

This is an office appointment and as such, any co-pay, balance or deductible is due at the time of service. The medical assistant will be taking your vitals and setting up the technology for you to have a private conversation with the medical provider. Most insurances cover costs of telemedicine in the state of California. In fact, this service is being encouraged as a means to provide healthcare in underserved areas. Please feel free to ask any questions and if at any time you are not comfortable please let one of our staff know. Lastly, we would like your feedback. At the end of your appointment the medical assistant will give you a short survey to fill out about the experience. We welcome your feedback and any suggestions. We are aware of the trust you put in us to deliver to you quality up to date healthcare. We thank you for that trust and hope that you find this experience to be a positive one as we are trying to create more appointment availability for our patients.

- *I understand that any co-pays, deductibles and/or account balances are due at the time of my Telemedicine Appointment.*
- *I understand that the provider will be communicating with me remotely through secure, HIPAA-compliant technology.*
- *I agree to have a telemedicine appointment at Dawes Family Medicine and that this consent will remain in effect until I notify the office otherwise.*

PATIENT NAME (PRINTED): _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

HEALTH EXAM QUESTIONNAIRE FOR MEN

NAME: **DATE:**

PERSONAL MEDICAL HISTORY:			**FAMILY HISTORY:**			**REVIEW OF YOUR BODY:**		
	Y	**N**	*Do you have a parent, sibling or child with*:	**Y**	**N**	*Do you know have any of the following?*	**Y**	**N**
Cancer			Colon Cancer?			Change in weight?		
High Blood Pressure			Prostate Cancer			Eczema or psoriasis?		
Cholesterol			Other Cancer?			New or changing mole?		
Heart Attack/Stroke			Diabetes?			Vision changes?		
STD/VD			High Blood Pressure?			Sinus problems?		
Migraines			Heart Attack or Stroke?			Hearing problems?		
Depression			**EXPLAIN:**			Sneezing or runny nose?		
Thyroid Disorder						Frequent headaches?		
Blood Clots						Fainting spells?		
Surgeries						Weakness or numbness?		
Diabetes			**HABITS/PREVENTION/SAFETY:**			Difficulty walking?		
EXPLAIN:			Do you exercise?			Difficulty sleeping?		
			Activity:			Feeling down, depressed or hopeless in the past		
			Current cigarette smoker?			month?		
WHEN WAS YOUR LAST:			Average # of cigarettes per day:			History of Psychiatry care?		
Physical?			Former cigarette smoker?			Asthma or wheezing?		
Skin Cancer Screening?			Do you drink alcohol?			Cough?		
Cholesterol Test?			When did you last have more than 4 drinks in one day?			Breathing difficulty?		
Tetanus Vaccine?						Chest pains?		
Flu Shot?						Heart murmur?		
Pneumonia Shot?			Have you ever felt you should cut down on drinking?			Racing heart?		
Eye Exam?			Do people annoy you by nagging about your drinking?			Swelling of hands or feet?		
Colonoscopy?						Abdominal pain?		

Bone Density Test?		Have you ever felt guilty about drinking?			Heartburn?		
Dental check-up?		Have you ever had a morning drink to steady your nerves?			Acid reflux?		
DRUG ALLERGIES (LIST)		Have you used recreational drugs in the last 3 years?			Diarrhea?		
		Drugs with needles?			Burning/painful urination?		
FOOD ALLERGY?		Have you had any falls?			Leakage of urine?		
PLANT ALLERGY?		Do you wear seatbelts?			Increased urination?		
WEED/GRASS ALLERGY?		Do you have firearms?			Difficulty starting urine?		
PET ALLERGY?					Weak urine stream?		
Other:		Do you experience conflict in your relationships handled by pushing, hitting or cruelty?					

DO YOU HAVE ANY OF THE FOLLOWING?	Y	N	**PRESCRIPTION MEDICATION NAME:**	**DOSE:**
Pain or lump in testicle?				
Erection difficulty?				
Lack of interest or loss of enjoyment with sexual intercourse?				
Breast lump or discharge?				
Joint pain or swelling?				
Knee pain?				
Back pain?				
Easy bruising?				
AVAILABLE HEALTH SCREENINGS ***- NOT COVERED BY INSURANCE please let us know if you would like more information on any of the following tests and/or exams that are available at our office.***				
Home Sleep Study Screening (sleep apnea is a major cause of heart conditions) $300				
Stroke & Aneurysm Preventive Screen $150				

Cognitive Dementia Screen $150				
Allergy Screen $450			**NON-PRESCRIPTION MEDS AND VITAMINS:**	

If you are scheduled for a Physical Exam today: The focus of your Annual Physical/ Preventive Health Visit is on maintaining health and preventing problems. You may have concerns or problems you'd like to address that are unrelated to the Preventive Health focus of today's visit, or new medical issues may be identified during your visit. If time permits, your provider may be able to address additional issues during today's visit. (*see below) If you have multiple concerns, complicated issues or new problems requiring additional evaluation, your doctor may suggest scheduling additional visit(s) in order to address these issues, or may address these issues today and suggest rescheduling your Preventive Health visit.

PLEASE LIST ANY ADDITIONAL ISSUES YOU HAVE TODAY:

* We are required to code procedures and diagnoses based on the services you receive. Appointments addressing both Physical Exams and medical problems often result in billing for both services. Depending on your insurance coverage, some or all of the cost may be billed to you. We cannot change the coding later to cause the insurance company to pay for a non-covered service.

PATIENT SIGNATURE: **DATE:**

Provider Review/Notes

Office Use Only (staff initials) ____/DATE_____

Consent for Release of Medical Information

Patient Name: _____ **SSN:** ___-__-____

Date of Birth: _____ **Chart#** _____

I, _____, give my permission to have any/and or all of my medical information, including financial, released to the following persons:

****

1. Name _____ **2. Name** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

Relationship: _____ **Relationship:** _____

****

3. Name _____ **4. Name** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

Relationship: _____ **Relationship:** _____

****

Patient Signature: _____ **Date:**_____

Witnessed by:_____ **Title:** _____

(Must be a Dawes Family Medicine employee)