Bear Valley Primary Care
12186 Hesperia Rd. Victorville, CA 92395
Ph: (760) 381-8848 Fx: (760) 381-8810

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ ☐ **Female** ☐ **Male** **SSN:** _____-_____-_____

Mailing Address: _____ **Apt/Suite/Unit:**_____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Marital Status: Married • Single • Divorced • Separated • Widow • Prefer not to answer

Race: White • African American • Asian • Eastern • Other:_____ **Ethnicity:** _____

Primary Language: _____ **Do you need a translator:** ☐ **Yes** ☐ **No**

Emergency Contact: _____ **Phone:** _____ **Relationship:**_____

Emergency contact is required by your insurance, if you REFUSE to provide one, please initial here: _____

Pharmacy Name: _____ **Address:** _____

Employer: _____ Occupation: _____

Address: _____ Apt/Suite/Unit:_____

City: _____ State: _____ Zip Code: _____

Work Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Member ID Number: _____

Secondary Insurance: _____

Member ID Number: _____

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Reason for visit: _____ **How many days/weeks:** _____

Is this a work-related injury/problem? ☐ **Yes** ☐ **No**

Medical History: *Do you have, or had, any of the following? Check only those that apply to you.*

☐ AIDS/HIV Positive	☐ Alzheimer's disease	☐ Anaphylactic	☐ Anemia
☐ Angina	☐ Arthritis/GOUT	☐ Artificial heart value	☐ Artificial joint
☐ Anxiety	☐ Blood disease	☐ Blood transfusion	☐ Breathing problem
☐ Asthma	☐ COPD	☐ Cold sores/Fever blisters	☐ Chest pain
☐ Cancer	☐ Chemotherapy	☐ Diabetes	☐ Diverticulosis
☐ Congenital heart disease	☐ Convulsion	☐ Depression	☐ Drug addiction
☐ Easily winded	☐ Epilepsy or Seizures	☐ Excessive bleeding	☐ Excessive thirst
☐ Fainting spells/Dizziness	☐ Frequent cough	☐ Frequent diarrhea	☐ Frequent headache
☐ Genital herpes	☐ Glycemia	☐ Hay fever	☐ Heart attack/Failure
☐ Heart murmur	☐ Heart Pace Maker	☐ Heart trouble/disease	☐ Hemophilia
☐ Hepatitis A	☐ Hepatitis B or C	☐ Herpes	☐ High Blood Pressure
☐ Hives/Rash	☐ Irregular heartbeat	☐ Kidney disease	☐ Leukemia
☐ Liver disease	☐ Low blood pressure	☐ Lung disease	☐ Pain in jaw joints
☐ Paramecium disease	☐ Radiation treatment	☐ Recent weight loss	☐ Renal dialysis
☐ Rheumatic fever	☐ Scarlet Fever	☐ Rheumatism	☐ Shingles
☐ Sickle cell disease	☐ Spina bifida	☐ Sinus trouble	☐ Stroke
☐ Swelling of limbs	☐ Thyroid disease	☐ Tonsilitis	☐ Tuberculosis
☐ Ulcers	☐ Venereal disease	☐ Yellow jaundice	☐ High cholesterol

☐ Alcohol Use:
Occasional / Moderate / Heavy

☐ Tobacco Smoker:
Former / Current

☐ Recreational Drugs:
Marijuana / Vaping / _____

Family History:

	Living Status	Diabetes	High Blood Pressure	Heart Disease	Mental Disorder	Cancer (Specify)
Mother						
Father						
Children						
Siblings						

Operations/ Surgeries: **NONE**

Name of Operation/Surgery	Year	Complications
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Allergies / Reaction **NONE**

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Signature: _____ **Date:** _____

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Medication List

Please list EVERY prescription and over-the-counter drug you are currently taking. Be Sure to include the strength and dosage of each medication, and how often it taken.

☐ **Not applicable, I'm currently not taking any medications.**

Medication Name and Strength	Direction, How Taking Medication
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

Signature: _____ **Date:** _____

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Patient Name: _____ DOB: _____

CONSENT TO MEDICAL SERVICES: The undersigned consent to the procedures which may be performed, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination medical treatment or procedures, services rendered to the patient under the general and special instructions of the patient's physician, and to participate in the patient and employee protection program.

PRESCRIBE: The undersigned authorizes bear valley urgent care to request and use patient's prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

RELEASE OF INFORMATION: The urgent care may disclosure all or any part of the patient's record to any person, company or corporation which is or may be liable under a contract to the urgent care or to the patient or to a family member or employer of the patient for all or part of the urgent care charge, including but not limited to hospital or medical service companies, insurance companies, workman's compensation, or welfare funds. The patient's record may be forwarded to the primary care physicians or to another facility in the event of transfer.

ASSIGNMENT OF BENEFITS: Insurance is billed as a courtesy to the patient and is not an obligation. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment of any insurance benefits otherwise payable to or on behalf of the urgent care, pursuant to this authorization, by an insurance company shall discharge said insurance company of all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and any applicable co-payments, co-insurances, or deductible amounts.

FINANCIAL RESPONSIBILITY: If the patient was evaluated by a physician, physician assistant and/or nurse practitioner at Bear Valley Urgent Care and was advised to go to another facility or physician for further treatment and evaluation, the undersigned agrees that they are responsible for any applicable co-payments, co-insurances or deductible amounts.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: "I hereby acknowledge that I have received a copy of the practice's *NOTICE OF PRIVACY PRACTICES.* I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES* should it be amended, modified, or changed at any time."

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the assignment of insurance benefits.

Signature: _____ Date: _____

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Pain Contract

I, _____, understand and voluntarily agree that
(initial each statement after reviewing):

_____ I will keep (and be on time for) all scheduled appointments with the doctor and the members of the treatment plan.
_____ I will participate in all other types of treatment that I am asked to participate in.
_____ I will keep the medication(s) safe, secure and out of reach of children. If the medicine is lost or stolen, I understand it will not be replaced until the next appointment and may not be replaced at all.
_____ I will take my medication as instructed and not change the way I take without first talking to the provider or other members of the treatment team.
_____ I will not call between appointments or at night or on the weekend looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.
_____ I will make sure I have an appointment for refills, if I am having trouble making appointments, I will tell a member of the treatment team immediately.
_____ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to the staff or disrupt the care for other patients my treatment will stop.
_____ I will not sell any medicine or share it with others. I understand that if I do so, my treatment will stop.
_____ I will sign a release to let my doctor speak to other doctors or providers, that I see.
_____ I will tell the doctor all other medication that I take and let him/her know right away if I have a new prescription/
_____ I will use only one pharmacy to get my medication from:
Pharmacy Name/Telephone Number: _____
_____ I will not get any opioid pain medication or any other medications that can be addictive, such as: Benzodiazepines or stimulants without telling a member of the treatment team before I fill those prescriptions. I understand that the only exceptions tho this is if I need pain medication for an emergency at night or on the weekend.
_____ I will NOT use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment will stop.
_____ I will come in for drug testing and counting my pills within 24 hours of being called. I understand that I must make sure the office has my current contact information to reach me.
_____ I will keep up to date with my bills from the office and tell the doctor or a member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.
_____ I understand that I may lose my right to treatment in this office if I break any part of my agreement.

Pain Treatment Program Statement

We here at Bear Valley Primary Care are making a commitment to work with you in your effort to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointments.
We will make sure that this treatment is as safe as possible. We will check regularly to make are you are not having bad side effects.
We will keep track of your prescriptions to help you feel like you being monitored well.
We will help connect you with other forms of treatment to help you with your condition.
We will help set treatment goals and monitor you progress in achieving those goals.
We will work with any other doctors of providers you are seeing so that they treat you safely and effectively.
We will work with medical insurance providers to make sure you DO NOT go without medications because of paperwork or other things that they may ask for.
If you become addicted to these medications, we will help you get treatment and get off the medication that are causing problems.

Patient Name: _____ **Date:** _____

Patients Signature: _____

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Advanced Directive Acknowledgement

Name: _____ **Date of Birth:** _____
Address: _____ **Telephone:** _____
_____

Advance Health Care Directives

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

1. **I am age 18 or older. (Circle one) 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 Doctor(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 – Ex. A Living Will**

c. **I may write my wishes on paper so that my family may use the docu**

d. **ment in deciding my medical treatment in the event I am unable to do so.**

Patient'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

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Consent to Use Telemedicine

Patient's Name: _____ My Doctor's Name: _____

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the stability of using telemedicine services by verifying my full name, current location, my readiness to proceed, and whether I am in a situation conducive to private. Uninterrupted communication. By signing this consent, I understand and agree.

1. My doctor is in and licensed by the state of California. My doctor may not be able to prescribe medications for me and /or may not be able to assist me in an emergency when I am in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.
2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and constructed in accordance with the laws of California.
3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use of telemedicine, no specific results can be guaranteed or assured.
4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor will refer me to a healthcare provider in my area who can provide such services.
5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in person healthcare services with my doctor.
6. I received an explanation of how electronic communications technology will be used for telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.
7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and it is free from distractions and intrusions during my telemedicine communications.
8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be transmitted through a secure device and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California law.
9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risk of privacy violation.
10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

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11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.
12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed all the questions I had with my doctor and all my questions were answered to my satisfaction.

_____ _____

Patient's Signature Date

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Policy For Prescription Refill

As of 03/01/2025 all controlled medications will require a visit every 30 days and medication will only be filled for 30 days only.

As of 03/01/2025 all maintenance medications will require a visit every 90 days for any refills.

_____ _____

Signature Date

_____

Print Name

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Medication Protocol

To our wonderful patients,

Here at Bear Valley Primary Care we take pride in handling your health and we are dedicated to give the best care possible. Our office will only prescribe 90 days refills for maintenance medications without any additional refills. Upon your 90 day prescriptions due date it is the patient's responsibility to schedule before his or her medication finished. Out scheduling number is (760) 381-8848 please promote to questions in order to schedule or before the end of your appointment please be mindful to schedule before you leave out office. Thank you so much for being a valued patient to our office.

Kind regards,

Management

Signature _____ Date _____

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Medical Records Record Request

Patient Name: _____ DOB: _____ Date: _____

[x] Requesting records **to be sent** to Bear Valley Urgent Care & Primary Care from the following…

Name: _____
Attention: _____
Address: _____
Phone: _____ **Fax:** _____

Please send the medical records from the following date from: _____ to: _____

- ❑ **Labs**
- ❑ **Imaging Reports**
- ❑ **Progress notes**
- ❑ **History and physical**
- ❑ **Consultation notes**

Purpose of requested use or disclosure

- ❑ **Continuing care**
- ❑ **Patient request**
- ❑ **Insurance**
- ❑ **Legal**
- ❑ **Other:** _____

I specifically authorize the release of the following information **(check and initial as appropriate)**

- ❑ **Mental health treatment information** **Initials**_____
- ❑ **HIV test results** **Initials**_____
- ❑ **Alcohol / drug treatment information** **Initials**_____

*If not checked and initialed the records containing such information can ***NOT*** be released.

Duration: this authorization expires: _____

*If no Date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to the address specified in the "requesting records from" section above. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some case not protected by federal confidentiality law (HIPPAA)

Conditioning: I may refuse to sign this authorization. If I refuse to sign this authorization, I should know that by law; my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. **This authorization is being requested of you to comply with the terms of the confidentiality of the medical information Act of I98I, civil code section 56 et seq. and the health insurance portability and accountability act (HIPAA) OF 2003.**

Patient/Legal Representative Signature: _____**Date:** _____