Carl Knopke, MD

Raincross Medical Group member / Inland Empire Weight Loss
4646 Brockton Ave., Ste 302, Riverside, CA 92506
951-231-1363 / 951-774-2723

Welcome to our office.

Thank you for choosing to use us as your primary care office. We are happy to have you. We will do our best to provide excellent service. You will notice when you walk in that we have received several awards for achieving high levels of patient satisfaction. Dr. Knopke has on several occasions been awarded as America's Top Doctor. We strive for the best but we learn from you. Should you have any concerns please let us know or feel free to call Dr. Knopke directly at 951-774-2721.

We do offer an extra service not found at other offices. We have a dedicated program in Obesity Medicine to help you lose weight and achieve optimal health. Our program is over 5 years in the making and we have many happy 'losers'. Dr. Knopke is a member of the Obesity Medicine Association and adheres to national guidelines in the design and implementation of the weight loss program. More information about the OMA, including a copy of the guidelines statement, can be found at www.inlanlandempireweightloss.com. If you are interested, please ask about making a special appointment to create your individualized weight loss program.

We pride ourselves on our high quality of service. Such service is only possible when adequate time is allowed to address your concerns. When you have a particular problem, we will work with you to find the best treatment options. However, if you have multiple concerns, then less time can be dedicated to each problem on a given visit. We may ask that you return on a different day to address your additional concerns. This keeps our clinic running on time and allows us to dedicate quality time to each of our patients.

Carl Knopke, MD

Raincross Medical Group member / Inland Empire Weight Loss

Board Certified Family Medicine and Obesity Medicine
and member of the Obesity Medicine Association

Today's Date: _____ Date of visit (if different): _____

General History*

Name:_____DOB:_____Age:_____
Sex: M F Wt:_____Ht:_____Marital Status: Married Single Divorced Widowed
Primary language: ☐ English ☐ Spanish ☐ Other_____
Last or Current Occupation and when:_____
Past Medical History:_____

Do you have an advanced directive (for ages >= 18 years old)?:
☐ Yes (Please leave a copy with our office) ☐ No → ☐ I want more information ☐ I have no idea what this is ☐ I don't want one
Past Surgical History:_____

Past Psychiatric History:_____

Current Medications (including herbs): _____

Medication Allergies (and describe the allergic reaction):_____

Family History – Chronic medical problems of your parents, siblings, and children and age of onset:

Social History: With whom do you live:_____Number of Children:_____
Smoking: Current Prior Never # of packs/day(avg):_____and # of yrs smoked: _____Quit Date_____
Alcohol – Please describe what, how much, and how often you drink:_____

History of recreational drug use:_____

Women only: Date of last PAP_____Ever abnormal? Y N Ever had colposcopy?_____
History of HPV (Human Papilloma Virus)?_____Date of Last MMG_____Ever abnormal MMG? Yes No
Last Menstrual period:_____ Age of onset Menses_____ Age of Menopause_____

Frequency of Cycle:_____Number days of flow:_____Current birth control method (include vasectomy):_____
Pregnant? Yes No Maybe Number of pregnancies:_____Number live births:_____ Trouble Conceiving? Yes No
Miscarriages:_____Number of Abortions – Medically Indicated:_____Elective:_____

Comments:_____

Doctor's Signature X:_____ Chart #_____

Raincross Medical Group / Inland Empire Weight Loss*

Patient Information

Patient Number:_____

Name:	Date of Birth:
Address:	Social Security #:
Address:	Sex: M F
City:	Language:
State: Zip:	Employer:
Home Phone:	Emergency Contact:
Work Phone:	Emergency Phone #:
Cell Phone:	Emergency Relationship:
Email:	Primary Care Doctor:

Subscriber Information

(The person who pays for health insurance premiums. Please fill if different from above)

Name:	Date of Birth:
Address:	Social Security #:
Address:	
City:	**Employer**:
State: Zip:	Emp Address:
Home Phone:	Emp City:
Work Phone:	Emp State: Zip:
Cell Phone:	

Insurance Information

Primary Insurance:	Secondary Insurance:
Member ID #:	Member ID #:
Group Number:	Group Number:
Group Name:	Group Name:
Subscriber Name:	Subscriber Name:
Primary Address:	Secondary Address:

*Pharmacy Information**

Name of Pharmacy:
Address:
Phone Number:

**If you do not know what pharmacy to use, the Provider can send your medication to the pharmacy downstairs*

Raincross Pharmacy

Open: Monday – Friday 8:30am – 5:30pm

☐ **Yes**, Send my medication downstairs

Assignment of benefit/Authorization

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedure, and others pay a percentage of the charge. It is the responsibility of the patient to pay any deductible, co-pay, co-insurance, or in cases where the care is not covered by insurance, you will be charged for the entire cost of the non-covered service.

The total charges for office visits will be due at the conclusion of the office visit. If there is a co-pay, this will be due at sign-in. We cannot bill co-pays, deductibles, or cash visit charges to you at a later date.

If this account is assigned to an attorney or collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including MediCare, private insurance, and other health plans to: Raincross Medical Group, Inc.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not they are paid for by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

Signed (patient or parent if minor) Date

Consent for Treatment

1. I voluntarily consent to such care including routine procedures and other treatment by Raincross Medical Group, Inc. professionals and their assistants, appointees, or consultants as is necessary in their judgment.
2. I am aware that the practice of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments or examination by Inland Empire Weight Loss or Raincross Medical Group, Inc.
3. I understand that for certain procedures deemed necessary by my physician I will be required to sign a Special Consent Form.
4. I understand that Raincross Medical Group, Inc shall not be responsible or liable for the loss of/or damage to any personal property.
5. I authorize the release by telephone, mail, fax, computer or personal delivery to any party responsible for my care, such information from my records as is required in order for the clinic and all entities providing services to obtain payment. This includes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement is received.

Patient Name:_____ Date of Birth:_____

Signature of Patient:_____ Date:_____

Signature of Parent/guardian:_____

HIPAA NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & accountability act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice. These include activities such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, training of residents and medical students, conducting clinical research, recruiting patients for research studies and providing customer service (such as conducting an internal quality assessment review).

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective and last revised as of February 18, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint you may contact:
The U.S. Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, D.C. 20201
(202) 619-0257 or 1-877-696-6775

Authorization to release information:

Do not release my information to anyone except as detailed in the HIPAA Notice of Privacy Practices

OR

I give permission to disclose medical information to the following: (Please list below)

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Recipient:_____ Relationship:_____ Contact phone:_____

Patient Rights and Responsibilities

Rights

- To receive service in a reasonable period of time.
- To receive medically necessary service
- To be treated with respect and courtesy.
- To receive all available information about your care and treatment, including risks and options.
- To have your medical coverage explained to you.
- To participate in treatment decisions.
- To refuse treatment
- To receive impartial access to treatment.
- To receive a second opinion regarding any treatment plan.
- To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
- To request review of your medical record by the physician, and to request corrections if necessary.
- To be given information on how to file a complaint/grievance.
- To formulate an advance directive if you have a life threatening illness or injury.

Responsibilities

- Having appropriate identification, insurance membership cards, coverage stickers, etc at the time of the appointment.
- Keeping appointments or contacting this office in advance to cancel an appointment.
- Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
- Providing complete and accurate information.
- Following the health plan you and the physician agree on.
- Being considerate of others.
- Providing legal documentation of guardianship or a minor being treated.
- Providing a list of person who may receive medical information about you, on your behalf, in an emergency.

I have read and understand the HIPAA Notice of Privacy Practices and Patient's Rights and Responsibilities as stated above. These policies may change from time to time. I may request a current copy of this form at any time. I also agree to release (or not release) information as per the Authorization to Release Information Section:

Patient Name:_____ Date of Birth:_____

Signatory's Relationship to Patient:_____

Signature:_____ Date:_____