Welcome to **Sierra Spring Family Wellness Cente**

Craig R. Johnson, MD Sherry Kirchheimer, FNP Jodi Wilson, FNP Trisha Martin, FNP

Name: _____(as written on ins card) Date of Birth: _____

Address: _____ Today's Date: _____

City: _____ State:_____ Zip code:_____

Home Phone:(_____) _____ O

Cell Phone:(_____) _____ O

Work Phone:(_____) _____ O

Check preferred number above for day communication

Please indicate your contact preferences:

	Routine Results	Confidential/Urgent results
Letter	O	
Cell Phone		O
Home Phone		O
Work Phone		O

Preferred language _____ Social Security Number: _____-_____-_____

Sex: Female Male Other: _____ Marital status: Single Married Divorced Partnered Separated

E-mail Address _____ (Be on the lookout for an email to set up an account for our secure patient portal, for communication purposes)

Note: Please present your current ***Insurance card*** *at each appt; you'll also need it for labs & specialists*

Primary Insurance Information (not necessary to fill out if you've provided ID card)

Company: _____ Member ID#_____

Subscriber's name _____ Group #_____

Secondary Insurance Information: Company: _____ ID#_____

Subscriber's name _____ Group # _____ -

Emergency contact: Name _____

Relationship: _____ Phone: _____

Pharmacy : _____ Phone: _____

Address: _____City: _____Zip code:_____

How did you hear about us?

Insurance Friend Family member Internet Other_____

Name _____ Date of birth _____

Office Procedures and Financial Policies

Thank you for choosing us for your healthcare needs.

As a courtesy, we will bill the insurance plan you provide us. It is important that you verify with your insurance carrier prior to your appointment that our office is in network with your specific plan. You are responsible for **thoroughly understanding** your insurance benefits, including what services will or will not be covered and any special facilities you need to go to for your yearly physical, labs, immunizations, and any tests our medical providers may order for you. Also, all **co-payments, deductibles** and **balances** are due on the day of your appointment.

If a portion, or all, of the costs of your appointment are deemed your responsibility, we will mail you a statement. *Please send in your payment within **30 days**, or call us to pay over the phone*.

Please let us know when booking an appointment if your insurance has changed.

_____
Initial

Appointments:

We ask that you arrive 10 minutes before your appointment time so our medical providers can stay on schedule and patients coming after you can be seen in a timely manner as well.

If you need to **cancel** or **reschedule** an appointment, we ask that you call us at least **2 days ahead;** this gives us time to fill the slot with someone who needs to be seen. At minimum, we require a **24 hour** cancellation notice – during regular business hours Monday – Friday.

Same day cancellations & rescheduling, not showing up to an appointment (No Shows) and arriving more than 10 minutes late are considered **broken appointments** and will result in a **$25 fee** for an Office Visit and **$40** for a Yearly Physical/Preventive/Wellness Exam.
Excessive broken appointments may result in being dismissed from our practice.

It is the patient's responsibility to know the date and time of his/her appointment. Appointment reminder calls are a courtesy.

_____
Initial

Prescription Refills:

Please contact your pharmacy a week before your refills run out.

Allow **48 business hours** to complete the refill request. Some prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by insurance.

We cannot refill a prescription if the patient has not been evaluated within 12 months.

Same day – urgent -** prescription refills may be subject to a **$15 fee

_____Initial

Forms:

Please completely fill out your portion of any forms you need signed. Hand them to the receptionist when checking in for your appointment; our providers are not able to take them in patient rooms.

There is a 72-hour turnaround for forms (will be faxed, mailed, or held for pickup) **Fee schedule:**

$0 – School/Work excuse notes, Pregnancy verification, PPD Skin test form
$10 – School, Work & Camp Physicals, Sports Clearances, DMV Parking placard
$20 – Driver license papers, Jury Duty, IHSS
$25 – Letters, Medical Records
$30 – EDD disability (paper or online), FMLA
$40- Sedgwick form

$15 additional charge may be added for any "urgent" forms.

_____
Initial

Same Day Appointments:

We reserve some slots each day for patients with urgent needs. Please **CALL** the office at 8:30 a.m., for one of the first come, first served appointment times. These are **CALL** in, not walk in appointments.

Authorization to Treat, Release of Information & Assignment of Benefits

I hereby authorize Sierra Spring Family Wellness Center to provide medical care & treatment, and release my medical information to my insurance company(s) as necessary for the payment of benefits. I also authorize my insurance company(s) to pay benefits directly to Craig R Johnson MD Inc dba Sierra Spring Family Wellness Center (SSFWC.) These authorizations remain valid and effective from the date of signing until revoked in writing.

Notice of Privacy Practices

By signing below, I certify that I have read & understood the HIPAA Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Financial Responsibility

I understand that I am financially responsible for the costs of all medical services, whether or not paid by insurance. SSFWC will bill my insurance Co. as a courtesy but any portion of my medical bill that does not get paid by my insurance including but not limited to co-payments, deductibles and non-covered amounts will be my responsibility due *at the time of service*. I understand that invoices sent by SSFWC are due upon receipt and that failure to pay balances due may result in my being denied additional services.

I acknowledge that I have read and understand my responsibilities and SSFWC's policies.

_____ _____
Signature of Patient or Personal Representative Date

_____
If Personal Representative signs, please state relationship to patient & explain authority to sign

SIERRA SPRING
FAMILY WELLNESS CENTER

Dear Esteemed Patients,

Effective January 1, 2023, all medical offices in California are required to share information regarding the Open Payments database. 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

http://openpaymentsdata.cms.gov

Sincerely,

Sierra Spring Family Wellness Center
Dr. Craig R. Johnson

Patient Signature: _____

Date: _____

Craig R. Johnson, M.D.

960 E. Green St., Suite 292
Pasadena, CA 91106
Phone: (626) 449-4494
Fax: (626) 449-4474

Date_____ **Name**_____

Date of Birth _____

Health History

Immunizations **Date**

Tetanus/whooping cough booster (TdaP) _____
Pneumonia vaccination (over 65) _____
Flu shot _____
Shingles vaccination (over 60) _____

Cancer screening

Colonoscopy _____
Mammogram (women only) _____
Breast exam (women only) _____
PAP smear (women only) _____
PSA (prostate blood test, men only) _____

Other screening

Bone density test(>65, women) _____
Aortic ultrasound (>65, history smoking) _____
Glaucoma screening _____
Cholesterol test _____
Blood sugar test _____

Diet (circle all that apply)

Regular Low salt Low fat Vegan Vegetarian Low carb Gluten-free
Mediterranean Pescatarian Other:

Exercise

Type: Hours per week:

Habits

Alcohol - What type of alcohol do you drink? How much?

Yes / No Have you ever felt you should cut down on your drinking?
Yes / No Have people annoyed you by criticizing your drinking?
Yes / No Have you ever felt bad or guilty about drinking?
Yes / No Have you ever had a drink first thing in the morning?

Smoking - Never / Current / Former

Type of tobacco: Amount: Years used: Year quit

Substances:

Yes / No Marijuana
Yes / No Other:

Emotional health:

During the past 2 weeks, have the following been a problem for you:

Yes / No Little interest or pleasure in doing things
Yes / No Feeling down, depressed, or hopeless

Family history: Relative, illness(es,) & age of onset. (i.e. cancer type, heart disease, diabetes, high blood pressure, high cholesterol, mental illness, etc…)

Medical illness history: Please list medical problems and note if resolved or active

Previous surgeries: Please list surgeries, date, side of body (if applicable), and reason

Obstetric history: (women only)
# of pregnancies:_____ # of births:_____
# of miscarriages:_____ # of terminations:_____
Birth control method:_____
Date of first day of last menses:_____

Medications: (Please list all medications, dosage/strength, frequency)

Allergies:

Review of systems: (Please circle all that apply**)**

Constitutional: chills, fatigue, fever, malaise, night sweats, weight gain, weight loss
HEENT: hearing loss, ear pain, ear drainage, sinus pain/pressure, sore throat, nasal drainage, visual changes, eye pain, eye discharge
Respiratory: chronic cough, cough, shortness of breath, wheezing, known TB exposure
Cardiovascular: chest pain, pain in legs when walk, swelling, palpitations
Gastrointestinal: abdominal pain, change in stools, constipation, diarrhea, blood in stools, heartburn, loss of appetite, nausea, vomiting
Metabolic/Endocrine: intolerance of cold, intolerance of heat, excess thirst, excess hunger
Neurological: dizziness, extremity numbness, extremity weakness, difficulty with walking, headache, memory loss, seizures, tremors
Psychiatric: anxiety, depression, difficulty sleeping
Skin/hair: brittle hair, brittle nails, hair loss, excess body hair, hives, itchy skin, mole changes, rash, skin lesion
Musculoskeletal: back pain, joint pain, joint swelling, muscle weakness, neck pain
Hematologic/Lymph: easy bleeding, easy bruising, swollen lymph nodes
Immunologic: contact skin allergy, environmental allergies, food allergies, seasonal allergies
Genitourinary (male): dribbling, pain with urination, blood in urine, excess urination, slow stream, frequent urination, accidental urine loss, inability to empty bladder completely
Genitourinary (female): pain with urination, blood in urine, excess urination, frequent urination, accidental urine loss, inability to empty bladder completely
Reproductive (male): problems with erection, discharge from penis
Reproductive (female): abnormal PAP, pain with menstruation, pain with intercourse, hot flashes, irregular menstrual cycle, vaginal discharge, breast lump, nipple discharge

Legal (Anyone, but especially for those over 65)

Do you have a legal document that spells out your wishes should you become incapable of making decisions and naming a person to make those decisions for you?

Yes - Please provide us a copy for your medical records

No - We encourage you to fill out the Five Wishes form, available online at www.agingwithdignity.org. This is a simple form, legally recognized in California and 39 other states.

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____ +_____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Sierra Spring Family Wellness Center
960 E. Green Street, Suite 292 - Pasadena, CA 91106
Tel: (626) 449-4494 - Fax: (626) 449-4474

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

EXPLANATION
This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Act of 1981, Civil Code Section 56 et. seq.

AUTHORIZATION
I hereby authorize, hospital or health care provider _____Ph./Fax#_____ to furnish to **SSFWC Dr. Craig Johnson,** medical records and information pertaining to medical history; mental or physical condition; services rendered; or treatment of:

PATIENT'S NAME: _____ **D.O.B.:** _____

This Authorization is limited to the following medical records and type of information:

☐ **Progress Notes** ☐ **Consultation Reports** ☐ **Imaging Reports**

☐ **Lab Results** ☐ **All Medical Records** ☐ **Other:** _____

USE
The requestor may use medical records and type of information authorized only for the following purposes: **Medical care of patient.**

_____

_____

DURATION
This authorization shall become effective immediately and shall remain in effect one year from the date below

RESTRICTIONS
I understand that the requestor may not further use or disclose the medical information unless authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

ADDITIONAL
I further understand that I have a right to receive a copy of this authorization upon my request.

☐ **YES** ☐ **NO** **Initial** _____

OFFICE USE ONLY

Date: _____

Copies - Called - Mailed
Hand carry - Faxes - Bin

Initials: _____

SIGNATURE:

Date: _____ Time: _____

Signature: _____
Patient / Representative/Spouse ('Financial Responsible Party')

If signed by other than patient, indicate relationship: _____

Witness: _____

A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient as a spouse or dependent for a health insurance plan policy, a nonprofit hospital plan, a health care service plan or an employee health plan.

It is a policy of this medical practice that we will adopt, and comply with our Notice of Privacy Practices, which shall be consistent with HIPAA and California Law.