Patient Registration

NAME:______________________ SOCIAL SECURITY # _____-_____-________ DATE OF BIRTH:_____/_____/______

ADDRESS:__________________________ CITY:______________ STATE:________ ZIP:________

SEX: ______M ______F DRIVERS LICENSE #:______________ STATE________

DAYTIME CONTACT NUMBERS: 1.(_______)________-______________ (circle one) Home Work Cell

2.(________)________-______________ (circle one) Home Work Cell

***ATTENTION*:** We will use all Day Time Contact Phone Numbers to contact you regarding appointment reminders, test results, issues regarding your treatment, collection purposes or other issues regarding your information.

Occupation (previous and/or current) ______________________________ Retired: Yes____ No____

MARITAL STATUS: S_____ M_____ OTHER_____ IF STUDENT: PART TIME _____ FULL TIME _____ Race: ______________

Primary Language Spoken:________________ Hospital Records at ____________________

NAME FAMILY DR.: ______________________ ***Phone #***______________

Address of Family Dr. ______________________________________

NAME OF REFERRING Dr.:______________________ ***Phone#***______________

Address of Referring Dr.

RESPONSIBLE PERSON, IF OTHER THAN THE PATIENT

NAME:________________________ RELATIONSHIP TO THE PATIENT ______________

ADDRESS:________________________ CITY______________ STATE________ ZIP________

Date of Birth of Responsible Party: _______/__________/___________

RESPONSIBLE PARTY DAYTIME CONTACT PHONE# (________)________________

SPOUSE/PARTNER INFORMATION

NAME:______________________ DAYTIME CONTACT PHONE: (_______) ______________

EMERGENCY CONTACT INFORMATION

NAME:______________________ RELATION TO PATIENT:______________ PHONE #(_____)__________
(Not living with you)

PRIMARY INSURANCE INFORMATION

Ins Type: Medicare _______ Medi-Cal______ PPO_______ HMO ______ No Insurance ______ Other ____________

PRIMARY INSURANCE:______________________ PATIENT RELATION TO INSURED:____________

INSURED'S NAME:______________________ MEMBER ID#______________ GROUP__________
(If other than patient)

SECONDARY INSURANCE INFORMATION

Ins. Type: Medicare supplement_______ PPO_______ HMO_______ Other______________________

SECONDARY INSURANCE:____________________ ID#______________ GROUP__________

INSURED'S NAME:______________________ MEMBER ID#______________ GROUP__________

BY MY SIGNATURE BELOW, I DECLARE THE ABOVE INFORMATION IS TRUE AND ACCURATE

Patient or Guardian Signature:__________________________ **Date:** ______/_______/______

OFFICE USE ONLY

Assigned Provider: _____ Dr. Woodhouse ______ Dr. Karon ______ Dr. Kini

Revised Sept 2006

COMMERCIAL INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ______________________________, and assign directly to _________________________________all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I hereby authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Insured/Guardian: ___________________________________ Date: ________________________

LIFETIME MEDICARE AUTHORIZATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to ______________________ for any services furnished to me by the medical group. I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the Physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, co-insurances, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _______________________________________ Date: _________________________________

SUPPLEMENTAL MEDI-GAP INSURANCE AUTHORIZATION

I hereby authorize payment to ________________________ for all claims filed on my behalf. The signature applies to all services billed to Medicare and is in effect until revoked by me, in writing, by me or my representative.

Beneficiary Signature: ____ Date: _______________________________

PATIENT FINANCIAL AGREEMENT

I, the undersigned agree to be responsible for the balance of my account. Although an insurance claim (if applicable) will be filed with my insurance company by the doctor on my behalf, negotiating payments through my insurance company ultimately is my obligation. If my insurance requires a referral/authorization form from my Primary Care Physician, I understand it is my responsibility to obtain this. If I have no insurance, I understand that payment will be made at the time the services are rendered unless financial arrangements have been made PRIOR to the services. A statement will be mailed to me each month showing the total balance due from me and will be considered past due within 30 days from receipt. Items billed to your insurance become past due if no reply is received within 45 days. If I am unable to make payment in full, I understand that I should call the billing department immediately to make payment arrangements. I understand that if no payment has been received from me or my insurance, or, if no financial arrangements have been made on my balance after 45 days, my account may be referred for collections. If my account is referred for collections, I understand that I will be responsible for the balance as well as all collection costs and reasonable attorney's fees.

Signature of Responsible Party: _____________________________________ Date: ____________________________