

1) PATIENT REGISTRATION

ACCT #:

DR. #:

DATE:

FIRST NAME	MIDDLE	LAST	BIRTH DATE	AGE
CIRCLE ONE: MR. MS MRS. MISS			SOCIAL SECURITY NO.	DRIVER'S LICENSE
STREET ADDRESS			CITY	STATE ZIP
HOME PHONE			WORK PHONE	DATE OF ILLNESS OR INJURY
MAY LEAVE MESSAGE WITH: <input type="checkbox"/> HOME ANSWERING MACHINE <input type="checkbox"/> WORK ANSWERING MACHINE <input type="checkbox"/> ANYONE ANSWERING HOME PHONE <input type="checkbox"/> ANYONE ANSWERING WORK PHONE <input type="checkbox"/> NONE				
EMPLOYER OR NAME OF SCHOOL			EMPLOYER ADDRESS	
SPOUSE'S NAME			SPOUSE'S EMPLOYER AND PHONE NUMBER	

2) PATIENT REFERRAL INFORMATION

REFERRED BY	PRIMARY MD	PHONE NUMBER
NAMES OF OTHER PHYSICIANS WHO CARE FOR YOU		

3) EMERGENCY CONTACT

NAME OF PERSON	RELATIONSHIP	WORK PHONE	HOME PHONE
STREET ADDRESS		CITY	STATE ZIP

4) INDIVIDUAL RESPONSIBLE FOR PAYMENT

FIRST NAME	MIDDLE	LAST	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____		
HOME PHONE	WORK PHONE	CELL PHONE	SOCIAL SECURITY #	BIRTH DATE	
STREET ADDRESS		APT. #	CITY	STATE	ZIP
EMPLOYER				PHONE NUMBER	
STREET ADDRESS		SUITE #	CITY	STATE	ZIP

5) PRIMARY INSURANCE COMPANY *Please present insurance card to the receptionist*

INSURANCE COMPANY NAME					
STREET ADDRESS		SUITE #	CITY	STATE	ZIP
NAME OF INSURED			BIRTH DATE	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____	
INSURANCE ID #			GROUP #	EFFECTIVE DATE	

6) SECONDARY INSURANCE COMPANY

INSURANCE COMPANY NAME					
STREET ADDRESS		SUITE #	CITY	STATE	ZIP
NAME OF INSURED			BIRTH DATE	RELATIONSHIP TO PATIENT: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD OTHER: _____	
INSURANCE ID #			GROUP #	EFFECTIVE DATE	

7) WORK RELATED INJURIES

NAME OF COMPENSATION INSURANCE CARRIER			ADJUSTER AND PHONE NUMBER		
CARRIER'S ADDRESS					
NAME OF EMPLOYER (AT TIME OF INJURY)			NAME OF SUPERVISOR AND PHONE NUMBER		
ADDRESS					DATE OF INJURY
AUTHORIZATION GIVEN BY			NURSE CASE MANAGER		PHONE NUMBER
INDUSTRIAL CLAIM/CASE NUMBER			KAISER PHYSICIAN AND OFFICE		KAISER ID #

OVER - PLEASE COMPLETE BACK OF FORM

PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

PATIENTS **MUST** FILL OUT PATIENT INFORMATION FORMS **PRIOR** TO SEEING THE DOCTOR

WE WILL ASK TO SEE YOUR INSURANCE CARD ON YOUR FIRST VISIT AND WILL SCAN YOUR CARD INTO OUR SYSTEM AS NEEDED TO KEEP OUR INFORMATION CURRENT. WE MAY ASK FOR THIS INFORMATION ON A REGULAR BASIS IN ORDER TO ENSURE THAT NO CHANGE IN BENEFITS OR CARRIER HAS OCCURRED. PLEASE NOTIFY US IF YOUR INSURANCE CARRIER OR POLICY HAS CHANGED.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. If co-pay is not paid at the time of your visit a \$20 billing fee will be charged to your account.

SELF-PAY: Self-pay accounts shall exist if a patient has no insurance coverage or no evidence of insurance coverage. For new patients, a payment of \$250 is expected on the day of your appointment before being seen by the health care provider. If you are unable to pay the \$250 please contact the billing office prior to your appointment. A discount off regular fees is offered for payment made at time of service.

NON-PARTICIPATING INSURANCE PLANS: As a service to our patients, we will bill as a non-assigned claim. Any outstanding balances are the responsibility of the patient.

REFERRALS: If your insurance plan requires a referral from your primary care physician it is YOUR responsibility to obtain it prior to your appointment and to have it with you at the time of the appointment. If you do not have your referral, YOU MAY BE REQUIRED TO RESCHEDULE.

ACCIDENT/WORKERS COMP CASES: For any work comp cases, appointments will only be scheduled through the work comp carrier. Auto accident cases require the date of injury, claim#, insurance company address, phone#, and contact person from the insurance company. All auto accident cases must be reviewed by our billing department prior to your initial consultation. Patients shall be financially responsible for medical services related to accident if insurance fails to pay in full.

MEDICARE: We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the co-insurance, which can be billed to a secondary insurance if you have one.

RETURNED CHECK FEES: Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a \$25 fee per check returned.

DISABILITY FORMS/PAPERWORK: There is a \$25 per form fee for the completion of paperwork or forms relating to disability (except CA EDD). This fee is collected prior to completion of the paperwork, and for each time the paperwork is required. Allow five working days for completion of forms. Forms are not billable to your insurance.

WE ACCEPT CASH, MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, AND CHECKS. YOU MAY ALSO MAKE CREDIT CARD PAYMENTS BY PHONE.

If you have any questions please call our Billing Department at 925-469-3130.

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

Patient Name (if different from Responsible Party): _____