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 | ❑ MALE ❑ FEMALE

STREET ADDRESS | CITY | STATE | ZIP

CELL PHONE | HOME PHONE | WORK PHONE | DATE OF ILLNESS OR INJURY

MAY LEAVE MESSAGE WITH: ❑ HOME ANSWERING MACHINE ❑ WORK ANSWERING MACHINE ❑ ANYONE ANSWERING HOME PHONE ❑ ANYONE ANSWERING WORK PHONE ❑ NONE

EMAIL ADDRESS | SPOUSE'S NAME

EMPLOYER OR NAME OF SCHOOL | EMPLOYER ADDRESS

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: ❑ SELF ❑ SPOUSE ❑ 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: ❑ SELF ❑ SPOUSE ❑ 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: ❑ SELF ❑ SPOUSE ❑ 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 up to $500 is expected on the day of your appointment before being seen by the health care provider. If you are unable to prepay for the service please contact the billing office prior to your appointment.

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.

NO-SHOW/LATE CANCELLATION POLICY: We reserve the right to charge you up to $50 for no-showing or not cancelling your appointment within 24 hours of your visit.

DISABILITY FORMS/PAPERWORK: There is a $25 per form fee for the completion of paperwork or forms relating to disability. 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): ____