PATIENT REGISTRATION

Name:____ E-mail:____________________@__________________

Social Security Number:____________________ Sex: Male Female Date of Birth:_________________________

Age:_______________ Marital Status: Single Married Widowed Divorced Separated Other__________________

Street Address:____

City:____ State:_____________ Zip:_______________________

Home Phone: (__________)___________________Mobile Phone: (__________)_______________________

Work Phone: (__________)___________________Occupation:_____________________________________

Employer:____

Employer Street Address:____

City:____ State:_____________ Zip:______________________

Spouse's Employer:____Occupation:______________________

Name of Insurance Company:____

Subscriber Name:____

Subscriber Relationship to Patient:____

Subscriber Social Security Number:__________________________ Subscriber Date of Birth:___________________

Person Responsible forCharges:____

Responsible Party Relationship to Patient:____

Street Address of Responsible Party:____

City:____ State:_____________ Zip:_______________________

Home Phone of Responsible Party: (______)___________________ Work Phone: (______)__________________

Emergency Contact Name:____ Phone: (______)________________

AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize and fully consent to treatment of the person named above and understand (regardless or my insurance coverage) I am ultimately responsible for the balance on my account for any professional services rendered. I hereby certify that the above information is true and correct. I hereby authorize the release of information needed to my insurance company.

Date:______________________________ Signature:____

PATIENT REGISTRATION CONTINUED

(FOR EMPLOYEE USE ONLY)

COPY OF DRIVER'S LICENSE:

COPY OF PRIMARY INSURANCE CARD (FRONT AND BACK):

Primary Insurance Carrier:________________________

Policy Holder's Name:____________________________

Relationship to Patient:__________________________

Employer:_______________________________________

ID #______________________ Group #_____________

Policy Holder's Sex: Male Female

Policy Holder's DOB:_____________________________

COPY OF SECONDARY INSURANCE CARD (FRONT AND BACK):

Secondary Insurance Carrier:_____________________

Policy Holder's Name:____________________________

Relationship to Patient:__________________________

Employer:_______________________________________

ID #______________________ Group #_____________

Policy Holder's Sex: Male Female

Policy Holder's DOB:_____________________________

PAST MEDICAL HISTORY

Name: ___________________________________ Date: __________________

Date of Birth:___________

List all past serious illnesses and operations:

Description	Year	Outcome

List all MEDCATIONS (prescriptions and over the counter) you are currently taking:

Medicine	Dose	Frequency	Reason/Illness

List ANY ALLERGIES to medication or food and the associated reaction:

____

____

____

Do you currently use tobacco? YES NO Packs per day _________________

If previously used tobacco – when did you quit? ___________________________

How much / often before quitting? _____________________________________

Do you drink alcohol? YES NO Drinks per day: _______ per week: _________

Ventana Health and Medical Center, Inc.
901 Oak Park Blvd. Suite 101
Pismo Beach, CA 93449

Phone: 805.489.2205 ◊◊◊ Fax: 805.489.2206

PAST MEDICAL HISTORY CONTINUED

Family History

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				

Patient confidentiality is a very important issue when it comes to giving test results, medication changes, and other medical information related to your health care. Please fill out the "Patient Acknowledgement for Use/Disclosure of Protected Health Information" form. List the names of family members (living with you) if you would like our office to leave health information with them if you are unavailable; or ask for our "Health Information Disclosure Form" to list the names of other individuals or groups with whom our office is allowed to leave the above information.

PATIENT ACKNOWLEDGEMENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:____

Date of Birth:______________

I understand that my health information is private and confidential. I understand that Ventana Health and Medical Center, Inc. (Ventana Health) works hard to protect my privacy and preserve the confidentiality of my health information.

Ventana Health has a detailed document called the "Notice of Privacy Practices." It contains more detailed information about how we may use and disclose patient health care information. I understand that I have a legal right to read the "Notice of Privacy Practices" before I sign this consent. Ventana Health may update this "Notice of Privacy Practices." If I ask, Ventana Health will provide me with a copy of the most current "Notice of Privacy Practices."

I may cancel this consent in writing at any time by doing the following:

1. Signing and dating a form that Ventana Health can give me called "Revocation of Consent for Use and Disclosure of Healthcare Information" or
2. Writing, signing and dating a letter to Ventana Health. It must state that "I want to revoke my consent to authorize the use and disclosure of my health information for treatment, payment, and healthcare operations.

If I revoke this consent, Ventana Health does not have to provide any further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Ventana Health's "Notice of Privacy Practices." My signature means that I agree and consent to allow Ventana Health to use and disclose my protected health information to carry out treatment, payment and health care operations.

X_______________________________________ _______________
Patient or Legally Authorized Individual Signature Date

____
Relationship to Patient if Signed by Anyone Other than the Patient

PATIENT ACKNOWLEDGEMENT FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION CONTINUED

Communicating with you is a necessary part of our continued care of your medical health. We may need to communicate with you for various reasons including, but not limited to lab results, appointment reminders, billing questions, etc. Please complete the following information:

Primary Phone: (______)________________

Please indicate any people that you give us permission to leave your health information with. If you would like to provide us with permission to give your health information to additional individual(s), please ask for our "Authorization to Disclose My Health Information" form.

Name:____________________________ Relation:________________

Name:____________________________ Relation:________________

Name:____________________________ Relation:________________

Name:____________________________ Relation:________________

Note: We cannot guarantee that cell phone calls are confidential due to the nature of this line of communications. If you choose to list you cell phone number, you will do so knowing that we cannot protect your confidentiality.

X____ __________________
Patient or Legally Authorized Individual Signature Date

____
Relationship to Patient if Signed by Anyone Other than the Patient

Ventana Health and Medical Center, Inc.
901 Oak Park Blvd. Suite 101
Pismo Beach, CA 93449

Phone: 805.489.2205 ◊◊◊ Fax: 805.489.2206

VENTANA HEALTH FINANCIAL AGREEMENT

VENTANA HEALTH AND MEDICAL CENTER, INC. IS COMMITTED TO THE HIGHEST QUALITY CLINICAL CARE AND CUSTOMER SERVICE ON CALIFORNIA'S CENTRAL COAST. THE FINANCIAL ASPECTS OF PROVIDING HEALTHCARE ARE COMPLEX AND DIFFICULT FOR BOTH PATIENTS AND PHYSICIANS AND WE HAVE INSTITUTED THE FOLLOWING FINANCIAL AGREEMENT IN ORDER TO CONTINUE TO MEET OUR PATIENTS' EXPECTATIONS OF THE HIGHEST STANDARDS. PLEASE REVIEW THIS BINDING DOCUMENT CAREFULLY AND ACKNOWLEDGE AGREEMENT WITH YOUR SIGNATURE BELOW.

1. PATIENTS ARE EXPECTED TO PAY ALL CHARGES IN FULL AT TIME OF SERVICE
   - We accept cash, personal checks, VISA or MasterCard.
   - For those patients with a health insurance plan with which we are contracted, we will file your claim to your primary insurance carrier; current insurance and identification cards are required by our office. Unless Medicare is your primary plan, we do not file claims with secondary insurance.
   - Your insurance is a contract between you and your health plan and it is your responsibility to know your health plan and its benefits. We allow 60 days from the date of service for your health plan to pay. After that time, <u>the unpaid balance will be your responsibility</u>.

2. CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES
   - Co-payments are a predetermined payment amount and will be collected on the date of service.
   - Co-insurance and deductibles may be calculated and payable on the date on service. These amounts are based upon your health plan contract. Please contact your health plan if you have any questions about your coverage.
   - If you are not prepared to pay the appropriate fees at time of service your appointment may be rescheduled.

3. NON-COVERED BENEFITS
   - From time to time patients request certain professional services that may not be covered by health plans.
   - These services are billed at our current cash rate. Examples of these services are:
     - Completion of prior-authorization forms for non-HMO plans — $20 per authorization
     - Patient-requested written correspondence — $75 per page
     - Applications and disability forms — $20 per page
     - Medical records copying (postage included) — $0.20 per page
     - Extended twenty minute appointments — No charge
     - Prescription refills and faxes — No charge

4. TRAVEL MEDICINE CONSULTATIONS
   - From time to time patients request medical services, vaccines, and prophylactic medications for infectious diseases in relation to recreational travel. These services are rarely covered by health plans.
   - If you are seen in our office for a travel medicine-related consultation, you will be charged our current cash prices for the office visit and for any necessary vaccinations. If, per patient request, the medical services are only provided via telephone, a flat consultation fee of $50 will be charged.
   - These cash charges are collected at the time of service. If you are seen in our office, we will file a claim with your health plan and refund any paid benefits.

5. TELEPHONE CONSULTATIONS
   - From time to time patients specifically request professional services to not be rendered in our office, but over the telephone. When clinically appropriate we will comply with these requests.
   - Claims will be submitted to your health plan for these services in accordance with CPT guidelines.
   - Some health plans choose not to pay for telephone consultations. If a claim is accurate, and is denied or not covered for any reason by your health plan, you will be responsible for the associated charge.

6. PREVENTATIVE HEALTH EXAMS
   - Annual exams, routine physicals, and "check-ups" are visits dedicated to preventative health and claims submitted to your health plan will accurately reflect this intention.
   - It is your responsibility to understand your insurance benefits. Many health plans, including Medicare, do not cover most preventative health exams.
   - Once filed and verified to be accurate, your claim will not be altered in any way and you may be responsible for the professional charges.

7. OPTIONAL NON-COVERED BENEFIT FEE
- In lieu of paying individually for non-covered services as determined by your health plan, patients may voluntarily pay an annual fee of $100 to cover all services listed in Sections 3, 4, or 5.
- This fee will pay for all non-covered benefits provided by our office for the following 12 months after its receipt and is not in lieu of or in addition to any reimbursement for services covered by your health plan.

8. MOTOR VEHICLE ACCIDENTS
- We do not contract with automobile insurers.
- Since injuries from motor vehicle accidents are covered by auto insurance policies and can be in dispute for extended periods of time, we require payment for all services related to auto accidents to be paid in full at the time of service at our current cash rate.

9. MISSED APPOINTMENTS/LATE CANCELLATIONS/INAPPROPRIATE BEHAVIOR
- Our office makes attempts to contact all patients for upcoming appointments. It is, however, solely your responsibility to manage your schedule and to keep appointments made with our office.
- Missed appointments represent a cost to us and to other patients who may have been seen in the time set aside for you. You must notify us of your cancellation at least 24 hours prior to the appointment.
- Patients who fail to keep their scheduled appointment without giving the required notice will be charged $50.
- Excessive missed appointments, and threatening or offensive behavior will result in discharge from the practice.

10. DELINQUENT ACCOUNTS
- Accounts past due are placed on a cash-only status, at which time all balances due from a patient must be paid in full at each visit.
- All fees, including but not limited to: collection fees, attorney fees and court fees that are incurred, will become your responsibility, in addition to the balance due to this office. There is a minimum of $50 collection fee applied by the practice to any account that is sent to an outside agency.
- Patients with delinquent accounts that necessitate involvement of an outside collection agency will be discharged from our practice.

11. RETURNED CHECKS
- There is a $30 service fee on all returned checks. Returned checks must be redeemed with cash or credit card within 14 days of being returned or the account will be considered delinquent.
- Two returned checks within a 12 month period will place your account on a cash-only status.

12. MINOR PATIENTS
- We require that a minor patient be accompanied by a parent or legal guardian on the initial office visit. Subsequent visits will require adult consent either by phone call or written permission to treat.
- The adult accompanying the minor patient is required to pay in accordance with our policies. Please send the patient with the appropriate payment method for their visit.
- We do not acknowledge or enforce the terms of divorce decrees or other civil settlements.

- ❖ I HAVE READ AND UNDERSTAND THIS BINDING FINANCIAL DOCUMENT AND AGREE TO ABIDE BY ITS TERMS.
- ❖ I UNDERSTAND THAT CHARGES NOT COVERED BY MY HEALTH PLAN, AS WELL AS ANY APPLICABLE FEES, CO-PAYMENTS AND DEDUCTIBLES ARE MY RESPONSIBILITY. THIS BINDING DOCUMENT PRESIDES OVER ANY PAST OR CURRENT AGREEMENT BETWEEN ME AND MY HEALTH PLAN.
- ❖ I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO VENTANA HEALTH AND MEDICAL CENTER WHENEVER NECESSARY. I AUTHORIZE VENTANA HEALTH AND MEDICAL CENTER TO RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE COMPANY WHEN REQUESTED OR TO FACILITATE PAYMENT OF A CLAIM.
- ❖ ALL QUESTIONS ABOUT THIS POLICY HAVE BEEN ANSWERED TO MY SATISFACTION.

____
PATIENT NAME (PRINTED)

X____ ____________________
SIGNATURE (PATIENT OR RESPONSIBLE PARTY) DATE