PATIENT REGISTRATION FORM

*By completing this questionnaire you provide us with important, basic information for our records. Please **PRINT** your answers so that our office can establish an accurate record with the information you furnish.*

Patient's Name: ____ **Date of Birth**: _____/_____/______
Last name, First name, Middle name, Nick name (if applicable) — Month / day / year

Patient's Home Address: ____
Street Number and Name

____
City, State, and Zip code

Home Phone: (________) ____________________ - *Home phone number is used for automatic appointment reminder calls*

Cellular/Work: (________) ____________________ - *List phone number at which you are most often able to be reached*

Email Address: ____

Every effort is made to protect patient privacy. However, in the case of an emergency, we may need to call someone on your behalf. Please list below the name of someone we have your permission to contact if necessary.

Emergency Contact: Name: ____**Relationship**:______________

Emergency Contact: Telephone No: (_______) ______________________

Patient Signature (required):____**Today's date:** _______________

Regarding Telephone Messages

- _ Patient privacy considerations prevent us from leaving medically-related messages on your voicemail/answer system(s) *unless you choose to authorize us to do so.* Authorizing the recording of medically-related messages on your voicemail/answering system(s) is your choice, not your obligation.
- _ If you choose to authorize us to leave medically-related messages on your voicemail or answer message system(s), please read and sign the following:

"I hereby authorize Tri-Valley Medical Center, Inc. / Walnut Creek Urgent Medical Care, to leave a message on the answering device at: (_______) ____
(Telephone number) ***(Location – "home," "office," etc.)***

I understand that the information contained in the message may concern test results, laboratory studies or general physician information. I further understand that said message may not be secure or private."

____
Signature Today's Date

"I have been given a copy of Tri-Valley Medical Center, Inc. / Walnut Creek Urgent Medical Care 'Notice of Privacy Practices.'"

____
Signature Today's Date

GENERAL INFORMATION

PATIENT PRIVACY

Your privacy is important to us. Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care complies with current state and federal privacy standards. Your health information will not be released by our office without your express permission except under required state and federal legal statutes. If you would like to authorize our office to release your personal medical information to another individual i.e.: husband, wife, parent, adult child, sibling, please sign the authorization below. You may revoke this authorization at any time by notifying our office in writing.

I hereby authorize Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care to release my medical information to the following individual: ____, relationship: ________________________. I understand that I may revoke this authorization at any time by notifying Tri-Valley Medical Center, Inc. in writing of my intention. Signed: _________________________________Date:____________

Please read and initial the following policy statements:

(Initialing indicates that you have read each policy statement.)

______ ***MEDICAL RECORDS***

(Initial) Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care, charges $25 for the service for the photocopying of medical information that you or another party requests. Charges for these services are based on a fee schedule set forth by the Patient Access to Health Record: Health & Safety Code 123100.

______ ***CANCELLING APPOINTMENTS***

(Initial) Appointments for physical/wellness examinations are in high demand. If you cannot keep a wellness examination appointment, we require your **cancellation notice no later than 48 hours prior** to your scheduled appointment. If (1) notice is not received 48 hours prior to your scheduled appointment and if (2) we are unable to fill your time-slot, we will charge you a $50 non-cancellation fee.

Other types of appointments require 24 hours' cancellation notice. If (1) notice is not received 24 hours prior to your scheduled appointment and if (2) we are unable to fill your time-slot, we will charge you a $25 non-cancellation fee.

______ ***ANNUAL WELLNESS/PHYSICAL EXAMS***

(Initial) Annual wellness/physical exams may not be a covered benefit of your health plan. ***Please review your plan's Evidence of Coverage for specific covered benefits OR call your health plan for verification of your coverage***. If an annual wellness/physical exam is a covered benefit, please confirm whether you may be seen *once per calendar year* OR ***365 days*** *from the date of last examination*. Our office is not responsible for monitoring the length of time between wellness/physical examinations.

______ ***LABORATORY & RADIOLOGY REQUISITIONS/ORDERS***

(Initial) Laboratory & radiology requisitions/orders/tests may not be a covered benefit of your health plan. Certain insurance companies require you to use designated laboratory/radiology facility. ***Please review your plan's Evidence of Coverage for specific covered benefits OR call your health plan for verification of your coverage.*** Our office is not responsible for laboratory/radiology services not covered by a patients' insurance plan. **Under no circumstances can coding for laboratory/radiology work be changed or resubmitted after an order has been executed and completed.**

______ ***PRESCRIPTION REFILLS***

(Initial) In order that we might serve you in a more efficient manner, please contact your pharmacy **72 hours in advance** of needing a prescription refilled. If you need mail order prescriptions written, please notify our office a minimum of **10 days** in advance of the mailing date for your prescriptions. Mail order prescriptions will be sent to the patient for processing to their mail order prescription contracted provider of pharmacy benefits.

Insurance Assignment Information

Insurance Subscriber Name: ____ DOB________________

Relation to patient if other than patient: ________________________ Social Security #: ________ ________ _______

Health Plan: __________________________________ HMO: ☐ Yes ☐ No Effective Date: __________

Group#: ______________ ID#:___________________________

Secondary Health Plan: __________________________ HMO: ☐ Yes ☐ No Effective Date: __________

Group#:_______________ ID#:____________________________

RESPONSIBILITY FOR PAYMENT

I acknowledge that acceptance of my insurance information is not a guarantee of payment by my health plan until the claim has been accepted and processed. I further understand that if my claim is not accepted for payment I am personally responsible for payment of medical services rendered to me.

RESPONSIBILITY FOR CO-PAYMENTS

I agree to pay all applicable health plan co-payments at the time of service. I understand that if (1) I do not pay my co-payments at the time of service, and if (2) an office billing statement is subsequently generated, I will be charged a $15 special processing fee.

PAYMENT DUE DATE

I understand that all health plan deductibles and charges for non-covered benefits are due and payable upon presentation of a billing statement from Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care.

DELINQUENT ACCOUNTS

I understand that Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care assigns delinquent accounts to RCM Billing Collections Services. In the event that my account is sent to collections, all family members will be asked to seek the care of a physician outside of this practice.

MEDICARE PATIENTS

Medicare covers one annual physical/wellness examination ***365 days*** *from the date of last examination* with the exception of a first time physical when the patient initially enrolls in the program and that if I choose to have a complete physical examination I will be responsible for payment of all charges not covered by Medicare.

PATIENT OR AUTHORIZED PERSONS' SIGNATURE.

I acknowledge that I have read the above payment policies of Tri-Valley Medical Center, Inc. & Walnut Creek Urgent Medical Care and abide by them. I further authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature: ____ *Date:* ________