Family Health and Wellness

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION					
Patient's last name: First: MI:				Marital Status (circle one) Single Married Divorced Separated Widowed	
Birth Date:	Age:	Sex: M F	Social Security No.:		
Street Address:	City:	State:	Zip Code:		
Mailing Address (if different):	City:	State:	Zip Code:		
Home Phone:	Cell:	Work:	Other:		
Spouse's Name:	DOB:	Contact Phone:			
Pharmacy:	Email Address:	Driver's License No.:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insured:	DOB:	Address (if different):	Phone Number:
Primary Insurance:	Subscriber:	Relationship to patient:	
ID#:	Group #:	Subscriber's DOB:	
Secondary Insurance:	Subscriber:	Relationship to patient:	
ID#:	Group #:	Subscriber's DOB:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Home phone no.:	Cell/work No.:

PLEASE READ AND SIGN THE BACK OF THIS PAGE

Family Health and Wellness

Ronald D. Hart MD / Eric Vincent N.P

1528 Plumas Ct Ste 100

Yuba City CA 95991

AKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

Our practice is dedicated to maintaining the confidentiality of health information of our patients. You may obtain a copy of our full Notice Of Privacy Practices form our receptionist at any time.

Your protected health information will be used by our practice or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

_____

Patient Name

_____

Patient Signature **Date**

AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION/ACCESS REQUEST FORM

I authorize Family Health and Wellness, 1528 Plumas Ct, Ste 100, Yuba City, CA 95991 to release:

Check all that apply: _____ Claims Records _____ Member Contact Records _____ Referral Records _____ Prior Authorization Records _____ Case Management Records _____ Disease Management Records _____ All	_____ (Patient Name) _____ (Date of Birth) _____ (Address) _____ (Telephone)

My records or information may be released to the following people I have listed:

_____ _____
(Name) (Relationship) (Name) (Relationship)

_____ _____
(Name) (Relationship) (Name) (Relationship)

Information will be used/disclosed for the following purposes(s):

_____

Time Limit/Right to Revoke

This authorization will never expire unless requested below:

_____

Re-disclosure

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Family Health and Wellness, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Signature of Individual or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization, and that I can inspect or copy the Protected Health Information to be used or disclosed.

I hereby authorize Family Health and Wellness to release the Protected Health Information as specified above.

_____ _____
Signature of Individual or Individual's Representative **Date**

_____ _____
Printed Name of Individual or Individual's Representative **Relationship of Individual's Representative**

Family Health and Wellness Financial Policy

Thank you for choosing Family Health and Wellness. If you are ever uncertain about any aspect of your payment responsibilities, we ask that you seek clarification from our patient account representatives.

Financial Responsibility and Claim Submission: Even if you have insurance, you are obligated to pay Family Health and Wellness for the services we provide you. Most often we will bill your insurance as a courtesy to you but if the insurance carrier does not pay, does not pay in full, or pays to slowly, after 60 days from the date of service we will bill you directly and payment will be due upon receipt of your first statement.

Insurance: We participate with many insurance plans, including Medicare. Knowing your insurance benefits is your responsibility as some services may not be covered. Please contact your insurance carrier with any questions you may have regarding eligibility or benefits.

Self Pay: If you do not have insurance coverage, payment in full is expected at each visit. If you are not able to make full payment, you will need to set up a payment arrangement.

Unpaid Balance: If your account balance is 90 days past due, your account may be referred to an agency for collection of for a legal proceeding. If that occurs, you will be responsible for paying all collection expenses, including the Clinic's attorney fees. You also may be dismissed as a patient.

Returned Checks: There is a $25 fee for each returned check. If we receive two (2) returned checks on your account we will no longer accept checks as payment.

Co-pays: Your co-pay must be paid at the time of service.

Proof of Insurance: We require a copy of your current insurance card upon check-in at your appointment. If we do not get the information, you will be treated as a self pay patient until proof of insurance is given. It is your responsibility to notify us of any change in insurance.

Authorization to release and Assign Insurance Benefits: By signing below (or signing below as legal guardian for a minor patient), you authorize release of any information required to act on any insurance claim and permit photocopy or other facsimile reproduction of this authorization to be used in place of the original authorization and assignment. You hereby assign to the Clinic the Medical and/or surgical benefits to which you are entitled from your insurance company and/or Medicare for service provided by the Clinic. This authorization is in effect for all future claims until you revoke it in writing. By signing below, you understand and agree to this Financial Policy. You understand that you are financially responsible for all charges incurred for your medical treatment.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO BE BOUND BY IT.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

family Health and Wellness
1528 Plumas Ct Ste 100
Yuba City, CA 95991
(530)755-1007
Fax: (530)755-1711

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____

To release to: **Dr. Ronald D. Hart M.D**
1528 Plumas Ct. Ste. 100
Yuba City, CA 95991

(Persons/Organizations authorized to receive the information, Please include Address)

the following information:

a. ❑ All health information pertaining to my medical history, mental or physical condition and treatment received

OR

❑ Only the following records or types of health information (including any dates):_____

b. I specifically authorize release of the following information (check as appropriate):

- ❑ Mental health treatment information
- ❑ HIV test results
- ❑ Alcohol/drug treatment information

PURPOSE

Purpose of requested use or disclosure: ❑ patient request; **OR**

❑ other _____

EXPIRATION

This Authorization expires ❑ 6 months ❑ 1 year ❑ other _____

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may revoke this authorization at any time, but I must do so in writing and submit it to the Medical Records Office where this form originated. For additional information see our Notice of Privacy Practices.

If the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Disclosures resulting from this authorization may be in written, electronic, and/or verbal form.

I have a right to receive and I will be offered a copy of this authorization.

A copy of this authorization is as valid as an original.

_____

Signature of ❑Client/Patient ❑Guardian/Parent/Conservator Date

If patient representative, enter relationship: _____

Witnesses: _____

Signature Date

_____

Signature Date

(If signed with a mark, two witnesses' signatures are required. One witness must also print the patient's or patient rep's name by the mark.)

family

Health and Wellness

Ronald D. Hart M.D

Cancelation Policy/ Check Policy

All cancelations must be made 24 hours prior to your scheduled appointments. If you fail to do so, there will be a **$50.00 "No Show"** charged to your account.

There will be a $ 25.00 bounced checked fee on top of the amount of check charged for any returned check.

Signature:_____Date:_____

Printed:_____Date:_____