

Northern California Arthritis Center

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Anthony S. Padula, M.D.

Angela M. Vega, NP

PATIENT INFORMATION SHEET

DATE: _____

Patient(H) phone:(____)_____

(C) phone: (____)_____

(W) phone:(____)_____

Name : _____

Please circle the preferred phone number to use for reminder calls or to discuss treatment.

Address: _____

City, State, Zip code

Birthdate: _____

Sex: M F Marital Status: S M D W Race: _____ Ethnicity: _____

Preferred language: _____

Emergency Contact Person: _____ Phone: _____

Insurance: _____

IF YOU ARE INSURED THROUGH ANY OF THE FOLLOWING NETWORKS, WE MUST HAVE A REFERRAL FROM YOUR PHYSICIAN PRIOR TO YOUR VISIT:

[] Hill Physicians Medical Group

[] Affinity Medical Group

[] Sutter Medical Group

[] Bay Valley Medical Group

[] Various other HMO plans (if unsure, please ask)

Subscriber Name: _____ Subs. Date of Birth: ____/____/____
(if other than self)

Referring Physician Name: _____
(if your referring physician is not local, please provide their phone no.)

Primary Care Physician Name: _____
(if different than referring physician)

We will make every effort to protect your privacy. Do we have your permission to leave messages regarding your appointment and/or treatment on your voicemail? ___ Yes ___ No

Please provide the names of persons allowed to receive information regarding your visits and/or treatment by our physician(s). _____ relationship? _____
_____ relationship? _____

PATIENT SCHEDULED TO SEE: [] R.K. DIXIT, M.D. [] R. B. DIXIT, M.D., Ph.D.
[] ZUZANA FOSTER, M.D. [] JOHN M. LOEB, M.D.
[] DAVID W. WU., M.D. [] ANTHONY S. PADULA, M.D.

AT: [] Walnut Creek [] San Ramon

Appointment Date _____ Time: _____ Made by: _____

AUTHORIZATION STATEMENT:

I request that payment of authorized benefits be made either to me or on my behalf to the Northern California Arthritis Center or the physician for any services furnished me by a physician of the Center. I authorize any holder of medical information about me to release any information needed to determine these benefits payable to related services. I also understand that I shall be responsible for any balance not paid due to co-payments, deductibles, denied claims and/or uncovered services.

HMO and EPO PATIENTS ARE RESPONSIBLE TO PROVIDE REFERRAL AUTHORIZATIONS FOR ALL OF THEIR VISITS.

PRIOR AUTHORIZATION POLICY:

Please note that while we will make every attempt to assist you in obtaining the necessary prior authorizations for visits and/or tests, your assistance with this is needed and appreciated. Each plan has rules that we must follow in order to provide you with the best medical care yet not go outside of your plan’s parameters. Sometimes this requires patience and a lot of follow-up.

If a medication is prescribed for you which is not on your plan’s formulary and prior authorization is required, a fee may be charged for this service. As an alternative you may request a substitution which is on your plan’s formulary. If you have any questions regarding your specific plan, please contact your member service representative for clarification.

PRESCRIPTION AND REFILL POLICY:

If you need a refill of medication that has been prescribed by one of our physicians, please call your pharmacy and they will fax and/or email us a request to authorize the refill. We will make every effort to respond the same day, however, this may not always be possible so please do not wait until the last minute to make your request. In as much as possible, notify your physician of your need for refills during your scheduled visit. Controlled substances/narcotics will not be filled on weekends or after hours by the physician on call.

FINANCIAL POLICY:

Payment of copays is required at the time of service. For those plans which have coinsurance amounts (i.e. Medicare, and PPO’s) we will allow you to withhold payments until the insurance has notified us of the coinsurance amount. Your portion is required within thirty days of the insurance companies notification and/or immediately due upon first statement.

Private pay patients are required to pay at the time of the visit. If you have any questions regarding our policy, please ask for assistance at your visit today or call our Billing Department at (925) 210-1050.

MISSED APPOINTMENTS:

Our physicians schedule time for your appointment therefore making it unavailable to other patients. This is why we have instituted a 24 hour cancellation policy. By giving us at least 24 hours notice on a cancelled appointment, we may be able to accommodate other patients who need to be seen. Any appointments that are cancelled without the minimum 24 hours notice may be subject to a fee of \$40.00. This is due directly from the patient and is not covered by the insurance companies.

MEDICAL RECORDS/DISABILITY FORMS:

There is a charge for copying your medical records and/or completing disability paperwork. This charge varies depending on the amount of records/information requested and must be paid prior to releasing the information. If the records are to be sent to anyone other than yourself, a Records Release form will need to be signed. Please allow 4-7 business days.

Call 925-210-1050 ext. 14.

I hereby acknowledge that I received a copy of this medical practice’s Notice of Privacy Practices and that I have read and understand the practice policies outlined above.

_____ Date: _____
Patient’s signature