Northern California Arthritis Center

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PATIENT INFORMATION SHEET

DATE: _____ (H) phone: (___) _____□

Name: _____ (C) phone: (___) _____□

Address: _____ (W) phone: (___) _____□

_____ Check preferred phone number for reminder calls.

_____Birthdate: ___/___/_____

Email: _____

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

Preferred Language: _____

Emergency Contact Person: _____ Phone: _____

Insurance: _____

Subscriber Name: _____ Subscriber Date of Birth: ___/___/____

(if other than self)

Referring Physician Name: _____ Phone: _____

Primary Care Physician Name: _____ Phone: _____

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 visit and/or treatment by our physician(s). _____ relationship _____

_____ relationship _____

Please review and sign practice policy at the back

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 physicians 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. Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for the services rendered.

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

INSURANCE CARDS: Due to the many ongoing changes in insurance, we require that you bring your insurance cards to the office for **EVERY VISIT** in order to bill your insurance.

PRIOR AUTHORIZATION POLICY: Please note that while we will make every effort to assist you in obtaining the necessary prior authorizations for visits, tests, or medications, your assistance with this is needed and appreciated. 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. **Please allow our staff 48 business hours to refill routine prescriptions.** Inasmuch 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.

FINANCIAL POLICY: Patients with copays will be expected to pay at the time of the visit in order to avoid a service charge. For those plans which have coinsurance amounts (i.e. Medicare and PPO's) we will allow you to withhold payment until the insurance has notified us of the coinsurance amount. Your portion is required within 30 days of the insurance company's notification and/or immediately due upon receipt of the first statement.

Patients who do not have insurance 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, ext 26.

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 company.**

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 for any other questions.

FEES: ***Medical Records***: $35.00 flat fee (fees waived if records are requested in writing from another physician's office); ***DMV, PG&E, Jury Duty form***s: $30.00; ***SDI and Social Security forms, FMLA:*** $85.00; Long/complicated forms of ANY kind: $100-175.00; ***Returned Check Charge:*** $25.00.

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

Patient Signature: _____ Date: _____