DIABLO FAMILY PHYSICIANS

2301 Camino Ramon, Ste. 180 San Ramon, CA 94583

Patient Information

Last Name: _____ First Name: _____ Middle: _____

SSN#: _____ DOB: _____ Gender: _____

Marital Status: _____ Emergency Contact & Relationship: _____ Emergency Contact Phone: ( ) _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) - _____

Email Address: _____

By checking this box, you are authorizing us to send you statements, payment receipts or other billing information related to today's services:
☐ Yes ☐ No

Primary Care Physician Name: _____ Primary Care Physician Phone Number: _____

Employer: _____ Is the visit related to a work related injury? _____

Ethnicity (White, Black/African American, American Indian, Asian, Hispanic/Latino, Native Hawaiian, other): _____ Language and Religion: _____

Do you need an interpreter? ☐ Yes ☐ No

Primary Insurance

Insurance Company: _____ ID#: _____ Group#: _____

Subscriber or Responsible Party Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____ ID#: _____ Group#: _____

Subscriber or Responsible Party Name: _____ DOB: _____ Relationship to Patient: _____

SELF PAY OPTION: Please initial if you have health insurance but you do not want your insurance billed and instead opt to pay out of pocket as self-pay ☐ I will pay out of pocket. Initial:

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Please make sure to complete all registration forms. Thank you!

Financial Acknowledgment For Testing Services

It is your responsibility to know your medical coverage, benefits, and deductible. While we order tests based on your health history and condition, there is no guarantee that your health plan will cover these tests and services, even if we believe they are medically necessary. Please work to verify your coverage and benefits with your health plan.

Understand Your Coverage:

- **Under no circumstances will we change or resubmit diagnosis codes after the testing is complete.**
- **Most health plans, including Medicare, do not pay for "preventative" testing.**
- **Most diagnostic testing will not be covered as a "preventative" service.**
- Diablo Family Physicians cannot guarantee coverage or payment by your Health Plan/Medicare.
- Our staff does not verify codes or coverage with your Health Plan/Medicare for services ordered.
- Your medical provider may still require lab work based on your medical history, medications, and symptoms.
- John Muir Physician Network HMO patients must only use Lab Corp facilities or pay all charges for not doing so.
- PPO patients are encouraged to seek care at an in-network facility for greater cost savings. Contact your health plan for more information on in-network testing facilities.
- If you have a high deductible health plan, you will pay for all services incurred until reaching your deductible.

Actions To Reduce Denials:

- Contact your Health Plan/Medicare representative to verify what is covered and what portion you are responsible for. Our team does not have access to the amount your health plan may charge for testing services.
- Ask your Health Plan/Medicare representative about lab and testing coverage. Your annual physical from Diablo Family Physicians does not include these services, which are provided by outside laboratories.
- Confirm that testing is under a "diagnostic" code, not a "preventative" code.
- Ensure that no other doctor has ordered these same tests as "preventative" for you this year.
- Check that you have met your insurance deductible before the testing is completed.
- Go to the preferred lab/facility that your Health Plan/Medicare requires.

I understand the above and accept full responsibility for any costs for medical services I have incurred both at Diablo Family Physicians and outside facilities. I am aware that Diablo Family Physicians cannot guarantee coverage nor verify network or coverage status for tests ordered. I understand that Diablo Family Physicians will not change or resubmit codes for tests with coverage issues. I understand a high deductible plan means I am responsible for all incurred expenses until that deductible has been met.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate name and relationship: _____ Telephone: _____

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NAME OF PATIENT: _____ **D.O.B** _____

Assignment of Benefits/Financial Policy: I hereby assign medical and/or surgical payments to include any medical benefits to which I am entitled to Diablo Family Physicians, Inc., for services provided by the stated medical group. I understand if claims are denied due to eligibility status, an invalid medical group, invalid Primary Care Physician, or any other reason, I will assume full responsibility for all charges incurred by myself and my dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles, and co-payments at the time of service. I am fully aware of the penalties of late payment of invoices/bills. For every additional invoice/bill sent after the initial invoice/bill I could be charged a $15.00 rebilling fee unless invoice is currently being discussed due to dispute in payment amount. This will be noted on your invoice/bill. There is a $25.00 returned check fee. If you do not have your co-pay at the time of service, there could be a $15.00 invoice/billing fee. **It is my responsibility to understand my insurance benefits and coverage plan.**

Initial Here _____

Cancellations/No Shows/Telephone Calls: Please call no later than 24 hours prior to the appointment to reschedule/cancel your appointment or this will be considered a no show. **The charge for a no show will be $50.00 for a routine office visit and $100.00 for a physical**. We reserve the right to bill for telephone calls for routine questions up to $10.00/call; we will notify you of the charge at the time of the call.

Initial Here _____

Form Completion/Photocopying: There will be a charge of $ 15.00 if you require a duplicate for a sports physical or single page school form. Forms greater than one page that are not received and completed at the time of visit (DMV, Disability, FMLA, etc…) will be $25.00. Copies of your medical record will be a minimum charge of $15.00 and then 25 cents per page. Letters written by the provider will start at a minimum of $25.00.

Initial Here _____

Limitation of our Responsibility: I understand that Diablo Family Physicians, Inc. makes no promises and is not responsible in any way financially for any non-covered benefits and does not guarantee or takes responsibility for in or out of network status related to your health plan. This includes but is not limited to any labs, tests, procedures, referrals, consultations, or any other medically related services that are recommended, ordered or submitted by this or any medical office. **We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage. We typically submit our office specimens to LabCorp Laboratories unless specifically requested at the time of service of every visit.**

Initial Here _____

Parental Consent for Treatment of Minor Without Parent Present: I hereby allow for the below minor child to receive medical treatment at Diablo Family Physicians, Inc. without my presence. If circumstances permit and state and federal privacy laws allow, I would like to have the provider consult in connection with such treatment. Please attempt to contact me at the below telephone number. This authorization shall be effective until the minor's 18th birth date.
The above policies will remain in effect until revoked by me in writing. A photocopy or scanned image of this document is considered as valid as the original. Any newer copy supersedes any previously completed notification forms.

Signed: Patient or Guardian: _____ Date:_____

If not signed by the patient, please indicate relationship:_____

- ☐ Parent or guardian of minor patient Telephone:_____
- ☐ Guardian or conservator of an incompetent patient

FOR OFFICE USE ONLY:
Reason for Inability/Refusal to obtain Signature:_____

Diablo Family Physicians Staff Signature/Name:_____ Date:_____

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FINANCIAL POLICY

- I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.
- It is my responsibility to verify with my insurance if BASS Medical Group is a contracted provider. BASS and/or its representatives will make every effort to assist you, but BASS will not be held accountable for understanding every insurance plan.
- I hereby authorize BASS Medical Group to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.
- I authorize the release of any medical or other information necessary to process claims for payment.
- I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.
- I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to BASS Medical Group. immediately upon receipt.
- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts.
- I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be a final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.
- I, the patient, or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: www.mbc.ca.gov.
- Lab services: I understand some or all laboratory tests may be sent to an outsourced lab for processing when necessary.
- Imaging Services: Attention Medicare patients only, if you are referred by a chiropractor for radiology services, please note, Medicare will not cover the billed charges.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the laboratory department of BASS Medical Group.

Signature of Patient, Parent or Legal Guardian	Relationship to Patient	Date

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).

- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  *Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name. alternative address. phone number. & email address of Spouse. as applicable:**

  _____

  ☐ **OK to Family Members: Please list name(s). alternative address. phone numbers. & email addresses of Family Member(s). as applicable:**

  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s). alternative address. phone numbers. and email addresses of authorized person(s) or entities:**

  _____

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM - Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address:

IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing.
You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/ they are signing (E.g., parent, guardian, conservator):

Name: _____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.