Patient Information Form

Last Name: _____

M.I.:_____First Name:_____

Social Security #:_____-_____-_____

Date of Birth:_____

Sex (circle) Male Female

Address: _____

_____

Zip:_____ State: _____

Home Phone: ( )_____ -_____

Emergency Phone: ( )_____ -_____

Mobile Phone: ( )_____ -_____

Fax# ( )_____ - _____

Alias (nickname): _____

Driver's License #:_____

Marital Status (circle):

Married Single Widowed Divorced

Email: _____

Responsibility party if patient is a Minor: _____

_____

Relationship to Patient: _____

Patient's Employer:_____

Occupation:_____

Employment Address: _____

_____

Zip:_____ State: _____

Work Phone: ( )_____ -_____

Spouse's Name: _____

Age:_____ State of Birth _____

Spouse' Employer: _____

Employer Address: _____

Zip:_____ State: _____

INSURANCE INFORMATION

Primary Insurance Co: _____

Insured: _____

Social Security #_____-_____-_____

Group Name and/or #: _____

Cert or ID #: _____

Address: _____

_____

Zip:_____ State: _____

WORKERS COMPENSATION

Employer (at time of injury): _____

Occupation:_____

Employment Address: _____

_____

Zip:_____ State: _____

Phone: ( )_____ -_____

Insurance Carrier: _____

Address: _____

_____

Zip:_____ State: _____

Authorization for Treatmeant: _____

I will be paying today by (circle): Cash Check Credit Card

I understand and agree that (regardless of my insurance status). I am ultimately responsible for the balance on my account for any profession services renderd. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of my changes in my health status or the above information.

_____

_____

Signature Date

_____

Parent or Guardian signature (if minor) Date

We are commited to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payments for services is due at the time services are rendered unless payments arrangements have been approved in advance by our Billing Department or Attending Physician. We accept cash, checks, MasterCard or Visa. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

We will gladly discuss your proposed treatmeant and answer any questions relating to your insurance.

You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered by each carrier.

   This applies only to compnaies who pay a perentage (such as 70% or 80%) of "U.C.R.". "U.C.R." is defined as usual, cutomary and reasonable by most companies.

   This statement does not apply to companies who reimburse based on arbitrary "shedule of fees" which bears no relationship to the current standard and cost of car in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrary select certain services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are renders. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contactt us promtly for assistance in the management of your account. Our staff is always available to assist you.

If you have any questions about the information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

HEALTHPOINTE

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov