PATIENT INFORMATION

PATIENT NAME:
____
LAST FIRST MIDDLE

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

MAILING ADDRESS:
____

ZIP CODE: ________________________ CITY: ____ STATE: __________

SEX: (circle one) FEMALE MALE

HOME PHONE #: (______) ______-_______ WORK PHONE #: (______) ______-_______ CELL PHONE #: (______) ______-_______

EMAIL ADDRESS: ________________________@_____________________________ LOCAL PHONE #: (______) ______-______

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

DATE OF BIRTH: _________/_________/__________ SOCIAL SECURITY NUMBER: __________-________-_______________

PATIENT'S EMPLOYER INFORMATION:

COMPANY: ____

CITY: ____ PHONE #: _____________________________________

ACCIDENT INFORMATION: DATE OF ACCIDENT:_______________________ WORK RELATED?______ AUTO:______ OTHER:__________

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME:
____
LAST FIRST MIDDLE

ADDRESS:
____

HOME PHONE #: (______) __________-___________________ WORK PHONE #: (______) __________-________________

DATE OF BIRTH: (REQUIRED) _________/_________/__________ SEX: (circle one) FEMALE MALE

SOCIAL SECURITY NUMBER: __________ - __________ - _______________

RESPONSIBLE PARTY EMPLOYER INFORMATION:

COMPANY: ____

CITY: ____ PHONE #: ____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:
____

ADDRESS: ____ PHONE: ________________________

SUBSCRIBER'S NAME: ____SUBSCRIBER ID NUMBER: ____________________________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________________________ GROUP NUMBER: ______________________________________

COPAYMENT AMOUNT: $ ____________________________ SUBSCRIBER DATE OF BIRTH: ________/__________/___________

Office use only: Insurance Card Scanned/Copied ___________initials Insurance Card NOT provided ________initials

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SECONDARY INSURANCE COMPANY:____

ADDRESS: ____ PHONE: ____________________________

SUBSCRIBER'S NAME: ______________________________________SUBSCRIBER ID NUMBER: ___________________________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________________________ GROUP NUMBER: ______________________________________

COPAYMENT AMOUNT: $ _________________________ SUBSCRIBER DATE OF BIRTH: ___________/__________/___________

IN CASE OF EMERGENCY PLEASE CONTACT:
NAME:____

PHONE NUMBER: _______________________ RELATIONSHIP: ___________________________________

Please complete reverse side

FINANCIAL INFORMATION

PAYMENT POLICY:

Payment is required for all services provided at the time they are given unless prior arrangements have been specifically made, including all co-payments and unpaid deductibles. We accept cash, check, and all major credit cards. Due to our once liberal credit policy, we are no longer able to send a bill for services or co-pays. Again, payment is required for all services provided today. In some cases you may be given the opportunity to purchase prescribed medication, or duplicate copies of any x-rays taken in our office. We will **not** bill these items to any insurance policy and you will be required to pay for them at the time of service. Any laboratory tests or x-rays done today may be sent to an outside laboratory/radiologist. You will receive a separate bill from that service provider who may not be contracted with your insurance company. We will assess a $20 fee if you fail to cancel any appointment.

INSURANCE POLICY:

We are happy to submit your claims to the insurance carriers, if you have provided us with **all** information regarding your policy *including* a copy of your most current insurance card today. Please remember that the financial obligation for treatment is between you and this office and your insurance policy is a contract between you and your insurance company. Please familiarize yourself with your policy benefits, as not all services are covered in all contracts. If your insurance company is NOT contracted with our physicians, you will be responsible for a $100 deposit to be paid at the time services are rendered, and we will require a credit card authorization to be kept on file which may be used for all remaining fees not paid by your insurance company. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

It is also your responsibility, as a patient and member of your insurance company, to follow the guidelines set forth by your policy. This includes, but is not limited to, obtaining necessary referrals and authorizations for service **prior** to being seen by Truckee Tahoe Medical Group, and notifying the office staff of any pertinent information about your policy that could affect payment of your claims.

MEDICARE POLICY: (Advanced Beneficiary Notice)

Medicare may not pay for certain services such as Annual Physical Examinations, Durable Medical Equipment, and some Immunizations. The fact that Medicare may not pay for a particular item does not mean that you should not receive it and your doctor may recommend it. We may bill you for items or services that Medicare does not pay for and you will be fully responsible for payment either out of pocket or through other insurance coverage that you may have. You do however have the right to appeal Medicare's decision.

HIPAA PRIVACY POLICY & AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I understand that I have the right to request a copy of the Notice of Privacy Practices and I authorize the release of any medical information necessary to process any insurance claim. I authorize Truckee Tahoe Medical Group to release any medical information including diagnosis, x-rays, test results, reports, and records pertaining to any treatment or examination rendered to me as he deems necessary to ensure the best medical care on my behalf.

I also authorize the following person(s) to receive information regarding my condition and care:

Name:______________________________________ Relationship:_________________
Name:______________________________________ Relationship:_________________

I have read and agree to the above office policies of Truckee Tahoe Medical Group. I also accept full financial responsibility for this account.

________________________________ ______________________________
Print Patient Name Date

________________________________ ______________________________
Signature Relationship to Patient

We value your trust in us as your health care provider and appreciate the opportunity to serve you