

PATIENT INFORMATION

PATIENT NAME: _____

LAST

FIRST

MIDDLE

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

MAILING ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

SEX: (circle one) FEMALE MALE

BEST CONTACT #: (_____) _____-_____-_____ WORK #: (_____) _____-_____-_____ OTHER 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: _____ OT HER: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION OR PARENTS IF PATIENT IS A MINOR

RESPONSIBLE 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: _____

GROUP NAME: _____ GROUP NUMBER: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER DATE OF BIRTH: ____/____/____

SUBSCRIBER ID NUMBER: _____

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

Office use only: Insurance Card Scanned/Copied _____ initials Insurance Card NOT provided _____ initials

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: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

PHONE NUMBER: _____ RELATIONSHIP: _____

Please complete reverse side

FINANCIAL INFORMATION

PAYMENT POLICY: Payment is required for all services provided at the time they are given. This includes co-payments, outstanding balances, and deductibles. For all un-insured patients we will collect a \$100.00 as a deposit towards the total cost of

your visit prior to any services being provided. The balance must be satisfied at the conclusion of your visit today. If you are unable to pay for your services in full at each visit, please notify our staff immediately as you may be referred elsewhere for treatment. We are no longer able to send a bill for services or co-pays. We will NOT advise you of the cost for services prior to them being provided. The staff may provide an **estimate** of costs, but this is NOT binding. 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 do not accept returns of any medical equipment provided to you. We must be notified of any dispute within 90 days from the date services are rendered. We will assess a \$20 fee if you fail to cancel any appointment, a \$25 fee for any returned check, and finance charges on all unpaid balances >90 days old.

INSURANCE POLICY: The following insurance carriers have contracted with us: Blue Cross PPO, Blue Shield PPO, Choice Care Network, First Health Network, Great West, Hometown Health, Interplan, Medicare, St Marys PHCN, Universal Healthcare Network, Tricare. If your insurance company is NOT contracted with our physicians, we will collect a \$100.00 as a *deposit* towards the total cost of your visit prior to any services being provided. All other out of pocket expenses must be satisfied at the conclusion of your visit. We will submit a total claim to your insurance carrier, 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. We will NOT advise you whether or not services will be covered by your policy. We DO NOT accept MEDI-CAL or TRAVELERS (FOREIGN) insurance plans. It is 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. As a courtesy, we will send you a statement after your insurance has adjudicated your claim. We must be notified of any dispute within 90 days from the date services are rendered.

MEDICARE POLICY: (Advanced Beneficiary Notice) Medicare may not pay for certain services such as Annual Physical Examinations, Durable Medical Equipment, and some Immunizations and you may be required to complete an ABN to receive these services.

HIPAA PRIVACY POLICY SHORT FORM: We are providing you with general information about a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), along with a brief overview of our Notice of Privacy.

What is HIPAA and how does the Privacy Rule affect you? When the Health Insurance Portability and Accountability Act HIPAA was passed in August of 1996 this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation on April 14, 2003. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is the individually Health Information (IIHI)? Any information that is created and retained by our practice, or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice? Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. 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. If you have any questions regarding this notice or our health information privacy policies, please contact us at TTMG 10115 W. River St, Truckee, CA 96161.

I have read and agree to the above office policies of Truckee Tahoe Medical Group. I have received and understand my HIPAA rights and consent to treatment and accept full financial responsibility for this account.

Print Patient Name

Date

Signature

Relationship to patient: (circle one)

SELF

SPOUSE

CHILD

OTHER