



**Patient Registration Form**

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Physical Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Type: Home Cell Work Message ok? Y N  
Alternate Phone: \_\_\_\_\_ Type: Home Cell Work Message ok? Y N  
Email: \_\_\_\_\_ Used for Dr contact: Y N Newsletter? Y N  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male Female  
Marital Status: S M D W O  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Responsible Party Information (Parent information if patient is a Minor)**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Insurance Information**

\*Primary Insurance Company Name: \_\_\_\_\_  
\*Patients Relationship to Insurance Subscriber: Self Spouse Child Other  
\*Name of Subscriber: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_  
\*Social Security Number: \_\_\_\_\_ Male Female  
\*Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

\*Secondary Insurance Company Name: \_\_\_\_\_  
\*Patients Relationship to Insurance Subscriber: Self Spouse Child Other  
\*Name of Insured: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_  
\*Social Security Number: \_\_\_\_\_ Male Female  
\*Insurance ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

*I certify that the above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.*

Patient/Responsible Party Signature: \_\_\_\_\_

Responsible Party's Relationship to Patient: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## **Health Information Practices Notice**

Law requires the privacy of your health information to be maintained as confidential and not shared with any outside parties. As such, IMC will not disclose any of your health information to any outside organizations, with the exception and purpose of:

- Professional referral to another healthcare provider, hospital, or clinic for diagnosis, assessment, or treatment.
- Collection of payment for services rendered (i.e. your insurance company).
- Office administration including phone calls. If you are not available to receive the call, a message will be left on your answering machine.

This is a summary of our disclosure practices. Full disclosure packet is available upon request at the front desk.

I understand that if I wish to place any restrictions on this IMC Health Information Policy, I must make my request in writing. My request can be placed at any time. IMC will review my request and respond within 30 days. I will address concerns to: Ellen Barnett, MD, Medical Director, 175 Concourse Blvd, Santa Rosa, CA 95403

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

## **Electronic Chart Storage and Information Sharing**

I understand that all practitioners at 175 Concourse Blvd. (IMC) use the same electronic medical record. All patient records are accessible for review by my treatment provider(s), with the exception of notes for psychological visits. I understand that I may request specific psycho-social information to be kept in the confidential section of my record. This information can only be released with my specific authorization to do so and is not available to other practitioners.

I also understand that the individual practitioners' at IMC may discuss diagnosis and treatment options between each other, for the benefit of an integrative approach to my healthcare.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

## **Patients Paying Privately (no insurance)**

I understand it is the policy of all individual practitioners' of Integrative Medical Clinic to require payment in full at the time of service. I understand I will be charged for any appointment cancelled with less than 24 hours notice, and may incur a 1.5 percent late fee for any outstanding bill over 30 days. Returned checks incur an additional \$25 charge.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

### **Medicare Authorization**

I request that payment of authorized Medicare benefits be made to The Integrative Medical Clinic of Santa Rosa for services provided by my practitioner. I understand my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If “other insurance” is indicated in item 9a of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. Integrative Medical Clinic agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. I further understand that I will incur a 1.5 percent late fee for any bills outstanding over 30 days. I understand appointments cancelled with less than 24 hours notice will be billed to me directly, and that there will be a \$25.00 fee for any returned checks.

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Responsible Party Signature

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Date

### **Courtesy Billing Patient Release**

I understand it is the policy of the Integrative Medical Clinic to require payment for services rendered at the time of visit. I agree to be financially responsible for all charges and pay for all services, whether or not they are covered by my insurance. I authorize the Integrative Medical Clinic to submit my medical and billing information to my insurance carrier in order that I might be reimbursed directly for any services that are covered by my policy. I understand that IMC will submit my bill as a courtesy to me and does not guarantee any insurance benefit. It is my responsibility to verify my coverage directly with my insurance carrier. I understand that I will incur a 1.5 percent late fee for any bills outstanding over 30 days. I understand I will be charged in full for appointments cancelled with less than 24 hours notice and that there will be a \$25.00 fee for any returned checks.

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Responsible Party Signature

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Date

### **Medi-Cal Policy**

I understand Medi-Cal is NOT accepted by any doctor or practitioner, currently practicing at 175 Concourse Boulevard. I agree to pay the 20% co-insurance that Medicare does not cover at the time of service and I understand that Medi-Cal cannot be billed for reimbursement.

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Responsible Party Signature

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Date

