Gilroy Family Medical Group

A Division of BASS
9460 No Name Uno Suite 115
Gilroy Ca 95020
Ph#408-842-3133
Fax # 408-842-2229

NEW PATIENT REGISTRATION

Date: ______________________ Social Security Number ________ - ________ - ________

Patient's Name: ____
Last Name First MI

Date of Birth: ______________ ☐ Male ☐ Female Marital Status: S M W D Age: ______

Mailing Address: ___________________________ City: ____________ State/Zip Code: ____________

Home Phone #: (______) ________ -- ________ Cell Phone #: (______) ________ -- ________

Email Address: ____

Patient's Employer: ___________________________ Work Phone #: (______) ________ -- ________

Language: ____________________ Religion: ____________________ /or ☐ Declines to specify

PATIENT'S INSURANCE INFORMATION

Primary Insurance Carrier: ____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other DOB of Insured: ______________

Secondary Insurance Carrier: ____

Insurance is through: ☐ Patient ☐ Spouse ☐ Parent ☐ Other DOB of Insured: ______________

If patient is a minor, are parents ☐ Married, ☐ Divorced? Custodial Parent ____________________

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact ____

Phone # (______) ________ -- ________ Relationship to Patient: ____________________

Medications & Allergy

Allergy to medications ____

List of all medications ____

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HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient can access this information. The law permits us to use or disclose your health information in the following, please read carefully:

- 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 patient's 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 and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

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 the reverse side 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.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- 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.

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HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2

We may use your information to contact you. For example, if you are not at home, this information may be left on your answering machine (voicemail) 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. Please designate who our offices can disclose your health information to by checking the boxes below.

Please mark all boxes that apply:

☐ **Ok, spouse (Name)** ____

☐ **Ok, family members (Names)** ________________________________

☐ **OK, mail records/results**

☐ **OK to leave message on voicemail or answering machine**

☐ **Do NOT release any information to anyone other than myself (the patient).**

☐ **DO NOT RELEASE TO**____

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Patient's Name: ________________________________ Date of Birth: ____________

Signed: ______________________________________Date: ________________

If person signing is not patient please provide:

Name: ____

Relationship to patient____

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BILLING AND FINANCIAL POLICY – pg 1

The following sets forth the policies of Gilroy Family Medical Group A Division of Bay Area Surgical Specialists, Inc. This Policy is intended to educate and clarify responsibilities of the patient, your insurance and our office in processing your claims and payments. Your insurance benefit is a contract between you and your insurance company. Please review this information and sign & initial where indicated below.

*I understand that it is my responsibility to furnish Gilroy Family Medical Group a Division of BASS with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered. We participate in most PPO's, HMO's and Medicare. **However, we are NOT contracted with Medi-cal & Medi-caid and we do NOT accept Worker's Compensation and treat Motor Vehicle Accident Injury.**

Initial ____________________

- It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. Please be aware that some and perhaps all or some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. Each insurance company has their own policies and or restrictions and they are subject to change at any time. Gilroy Family Medical Group a Division of BASS and/or its representatives will make every effort to assist you but will not be held accountable for understanding every insurance plan. **You agree to be financially responsible for the cost of services that are not paid by your insurance plan, copays & deductibles.**

  Initial__________________

- I understand that if I provide your office with secondary insurance, you will forward the claim to the secondary carrier. If you're insurance primary or secondary deny any services or does not cover any service as part of their medical policy, you agree to be financially responsible for the services provided.

  Initial____________________

- 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 three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "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.

  Initial__________________

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BILLING AND FINANCIAL POLICY – PAGE 2

All forms and letters (written on your behalf) filled out by the physician are subject to a fee accordingly, minimum of $20 fee.

A copy of your medical records can be provided upon receipt of written authorization of release signed by the patient or guardian. All record request is a subject to fee accordingly, minimum of $15 plus .25 cents each page.

I understand that the clinic may also take a verbal request by me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

You will be charged $30 fee for no show for the following (30 min appointment) New Patient & Physicals & $20 fee for no show for established patient appointments.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of Gilroy Family Medical Group a Division of Bay Area Surgical Specialists, Inc.

Patient's Name: ______________________________ Date of Birth: __________

Signed: ______________________________ Date: ________________

If person signing is not patient please provide:

Name: ______________________________

Relationship to patient: ______________________________