

Gilroy Family Medical Group

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

PATIENT REGISTRATION FORMS

Date: _____ Social Security Number _____ - _____ - _____

Patient's Name: _____
Last 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: _____ ID # _____

Insurance is through: Patient Spouse Parent Other Subscriber DOB: _____

Secondary Insurance Carrier: _____ ID # _____

Insurance is through: Patient Spouse Parent Other DOB of Insured: _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact _____

Phone # (_____) _____ -- _____ Relationship to Patient: _____

IF PATIENT IS A MINOR

Parents are Married, Divorced, Custodial Parent: _____

Most insurances require us to gather this information from you every calendar year.

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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 – Please Read Carefully Page 1

The following sets forth the policies of Gilroy Family Medical Group A Division of Bay Area Surgical Specialists, Inc (BASS). 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 ask you to check if Bay Area Surgical Specialist (BASS) is in network as the billing is under BASS.**

Initial _____

We are NOT contracted with Medi-Cal or Medi-Caid and we do NOT accept Worker's Compensation or 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 your primary or secondary insurance 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 _____

continue next page

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BILLING AND FINANCIAL POLICY Please Read Carefully 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.

Initial _____

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.

Initial _____

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.

Initial _____

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

Initial _____

If you have been discharged from our practice for any reason, we ask you to find another provider outside of this practice.

Initial _____

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: _____

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Advanced Beneficiary Notice (ABN)

Today's Date: _____

Print Patient Name

DOB

I understand that today's visit may or may not be a covered benefit under my insurance plan. If the charges are denied for any reason, I will be financially responsible for the charges and will pay the first invoice from the Billing Dept. at BASS MEDICAL GROUP upon receipt.

Sports Physical

Biometric Exam

TB Risk Assessment

Initial _____

Patient or Responsible Party Signature

Date signed

Medicare Patient Only

Medicare does not pay for everything, even some care that you or your health care providers have good reason to think you need. We expect Medicare may not pay for the services listed below.

TDAP

Hepatitis A & B

Hepatitis A

TB/PPD

Initial _____

I have read the above and understand I will be financially responsible and will pay the balance in accordance with the practice financial policies.

Patient or Responsible Party Signature

Date signed