PATIENT INFORMATION FORM

*(PLEASE COMPLETE **ALL** SECTIONS OF THIS FORM)*

PATIENT INFORMATION

DATE ____________________

NAME ____________________

SS # ____________________

DOB ____________________

ADDRESS ____________________

CITY ____________________

ST / ZIP ____________________

HOME # ____________________

WORK # ____________________

CELL #

GUARANTOR INFORMATION

NAME ____________________

PHONE # ____________________

SS # ____________________

DOB ____________________

MEDICAL HISTORY

CURRENT MEDICATIONS

REASON FOR TODAY'S VISIT

DURATION OF ILLNESS

Method of Payment: (*For Co-Pay & Self-Pay)*

CASH CHECK CREDIT CARD

(CHECKS ARE ELECTRONICALLY SCANNED)

HEALTH INSURANCE INFORMATION

NAME OF PRIMARY INS. CO

EMPLOYMENT

HOW DID YOU HEAR ABOUT US?

PRESCRIPTION DRUG POLICY

Due to the nature of our practice, please be advised that the physicians of Avecina Medical 1) Do not provide narcotics for chronic pain management. 2) Do not dispense OXYCODONE or any other Class 2 drug. 3) Do not authorize refils for antibiotics without a follow up visit for re-evaluation of your medical condition. 4) Do not provide primary care management of chronic medical conditions. 5) Are not responsible for lost or stolen prescriptions

****By signing this registration form, you are stating that you understand this medication policy.*
*If you have any questions regarding this policy, please do not hesitate to ask to speak with a member of the management team.****

Thank you for your cooperation and understanding of this policy

CONSENT FOR TREATMENT AND MEDICAL RECORDS RELEASE

Consent and Authorization for Routine and Treatment:
I hereby consent to and authorize **Avecina Medical**, and my physicians or healthcare providers (both herein "Avecina") to provide medical care necessary for treatment of my medical condition.

Patient or Responsible Party ______________________________(Please intial)

Assignment of Benefits:
I hereby assign **Avecina** and my providers payment from all third party payers with whom I have coverage or from whom benefits are or may become payable to me, for the charges of my healthcare services I receive for, related to, or connected with this visit and any future visit for which I have medical insurance coverage.

Patient or Responsible Party ______________________________(Please intial)

Consent and Authorization for Release of Information: Cooperation:
I hereby authorize Avecina and my providers to release copies of my billing and medical records, and applicable healthcare information, to ensure payment for healthcare services I receive for, related to, or connected with this visit(s), to secure additional treatment if needed and to otherwise facilitate healthcare operations related thereto, to the following persons or entities: any Avecina provider, my referring or treating providers, the Guarantor on my accounts, and third party payers* or their agents. I also authorize the release of my healthcare information to regulatory entities and accrediting organizations as necessary to secure payment for services provided to me.

Patient or Responsible Party ______________________________(Please intial)

Guarantor/Patient Agreement:
I hereby agree to the following: (I) I am responsible for the charges of all healthcare services the "Patient" receives for, related to, or connected with this visit(s), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are readily available from any Avecina staff member and am fully aware at the time the healthcare services are provided. (ii) If Avecina bills third party payers*, they do as a courtesy, and Avecina may demand payment in full of any balance due, at any time. (iii) I understand that Avecina may bill me separately. (iv) If I am more than thirty **(30) days** overdue in the payment of any bill, **a finance charge of up to $10 per month will accrue on the unpaid balance every month until paid in full. (v)** If I am more than ninety days (90) days overdue on the payment of the final bill, I may be declared in default, and the overdue account may be referred to a collection agency, in which case I agree to pay attorney's fee, court costs and/or collection agency fees associated with the collection process.

* Third party payers include, but are not limited to, coverage available from, Medicare, Tri-Care, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

Our staff will do everything possible to verify your insurance benefits and eligibility. If treatment is AFTER HOURS or on WEEKENDS AND WE ARE UNABLE TO VERIFY YOUR MEDICAL INSURANCE COVERAGE

Please be advised that due to the nature of our practice, payment for physician services is expected at the time of service.
We accept Cash, Checks (must be imprinted with name and address and will be electronically scanned), Debit Cards, MasterCard, Visa American Express and Discover. Avecina Medical accepts most insurance plans and will be happy to file your insurance provided that eligibility, deductible and co-payment amounts can be verified prior to seeing the physician.
Otherwise, PAYMENT IN FULL WILL BE EXPECTED AT THE TIME SERICE IS RENDERED
For your convenience, Avecina Medical Center can either submit the claim on your behalf to your insurance company or we will provide the appropriate form so that payment made to Avecina can be reimbursed to you by your insurance company or applied toward your annual deductible, which ever is applicable.
******PAYMENT POLICY MUST BE ACKNOWLEDGED AND ACCEPTED PRIOR TO SEEING THE PHYSICIAN*******

Payment Policy Acknowledged and Accepted by Patient or Responsible Party _________________________(Initial)

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me, which shall also apply to Patient's child(ren) or legal dependent.

Patient/Guardian: Date: