CENTRIC HEALTH

Patient Registration

Today's Date:_____

_____ _____ _____ _____
Last Name First Name MI Date of Birth

_____ _____ _____ _____
Address City State Zip Code

(____)_____ (____)_____ Gender: ☐ Male ☐ Female
Home Phone Cell Phone

_____ _____ _____ (____)_____
Social Security # Marital Status Employer Name Work Phone

Which phone numbers may we leave a message:
☐ Home
☐ Cell
☐ Work

May we use the following methods to contact you?
☐ Text
☐ Email:_____

Race:
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Hispanic
☐ Other:_____

Ethnicity:
☐ Hispanic or Latin
☐ Not Hispanic or Latin

Primary Language:
☐ English
☐ Spanish
☐ Other:_____

Responsible Party Information

Check if Same as Patient ☐

_____ _____ _____ _____
Last Name First Name MI Date of Birth

_____ _____ _____ _____
Address City State Zip Code

(____)_____ (____)_____ Gender: ☐ Male ☐ Female
Home Phone Cell Phone

_____ _____ _____ (____)_____
Social Security # Relationship to Patient Employer Name Work Phone

Insurance Information

(Copies of ALL cards MUST be provided)

Primary Insurance Carrier:_____ I.D.#_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

Secondary Insurance Carrier:_____ I.D.#_____

Subscriber Name:_____ Relationship to Patient:_____

Subscriber Date of Birth:_____ Subscriber Employer:_____

In order to better serve you and provide quality care and service please provide us with the following information:

Pharmacy Information:
Local Pharmacy Name:_____

Address:_____ Phone #:_____

Mail In Order Pharmacy:_____

Mail in Order Pharmacy Location:_____ Phone #:_____

Other Providers currently involved in your care:

Physician Name	Phone #	Specialty	Month/Year of last visit

Are you currently in a Skilled Nursing Facility? ☐ **No** ☐ **Yes; Name of Facility:**_____

CENTRIC HEALTH

Emergency Contact Information

Please provide us with three (3) Emergency Contacts, and whether or not we are authorized to disclose medical information.

Contact Name	Phone #	Relationship to Patient	Authorized to receive medical information?
			☐ Yes* ☐ No
			☐ Yes* ☐ No
			☐ Yes* ☐ No

***Authorization for use and disclosure of my health information.**

I voluntary authorize **Centric Health** to use or disclose my health information including but not limited to appointments, conditions, and treatments during the term of this Authorization to the recipient(s) that I have identified above. The information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the Privacy Rule.

I understand that this authorization shall be effective:

- ☐ Until I have requested this authorization to be revoked in writing.
- ☐ The date of this authorization until the _____ day of _____, 20____
- ☐ Until the following event has occurred:_____.

I hereby authorize the permissions as indicated above. I understand I have a right to a copy of this authorization.

_____ _____

Patient or Legal Representative Signature | Patients Printed Name

_____ _____

Relationship to Patient if other than self | Date

_____

Patients Date of Birth

Prescription History Consent

I hereby authorize **Centric Health** to access and use my electronic prescription history. I understand by doing so I am allowing **Centric Health** to access a full electronic history of prescriptions that have been prescribed to me by any and all of my healthcare providers including but not limited to hospitals, urgent cares, dentists, and private practice physicians. I am also allowing **Centric Health** to access records in regard to prescriptions filled in my name by local, mail order, and specialty pharmacies.

I understand this authorization shall not expire unless I submit a written request.

_____ _____

Patient or Legal Representative Signature | Date

Financial Policy Agreement

Thank you for choosing our office for your medical care needs. We are part of **Centric Health**, a multi-specialty group practice, and we look forward to being your healthcare provider. We are committed to providing you with superior and quality healthcare. We appreciate your commitment to adhere to this Financial Policy Agreement. **PLEASE NOTE: This financial policy applies to ALL Centric Health Divisions.**

Patients with Medical Insurance Benefits:

It is your responsibility to provide our office with a picture I.D., and valid insurance coverage information. You must notify us of any changes in your insurance coverage immediately. Many insurance companies have timely filing limits, if you provide us with insurance information after those limits have expired, you will be responsible for those services.

We are participating in most major health plans. We have contracts with many PPO's, HMO's, insurance companies as well as government agencies including Medicare. Our business office will submit claims for any services rendered, and assist you in any way reasonable to help get your claim paid. Your insurance may delay and/or deny claim payment pending requested information from the subscriber of your plan; it is your responsibility to comply with their request. Any such delays or denials will be your financial responsibility.

Copay's, Co-insurances, and Deductibles:

All co-pays, co-insurances, deductibles, and current balances are due prior to services being rendered. If such payments are not made at the time of service, our business office will send you a statement for your balance. It can be difficult at times to offer an exact quote of your portion due, we can however offer an estimation upon request. Under no circumstances is an estimation considered final payment or payment in full. Balances on claims are not considered final until after your insurance has processed the complete claim.

Non-covered and Out-of-Network Services:

Medical services considered by your insurance company to be non-covered, out-of-network, or not medically necessary will be your responsibility. Our office will attempt to verify benefits for services provided, but it is ultimately your responsibility to know your coverage.

Patient's WITHOUT Medical Insurance Benefits:

We recognize that some of our patients may be without insurance coverage or choose to receive care from our providers even when we are not considered 'participating providers' with their health plan. We offer reasonable discounted fees, as well as payment plans. Please let us know in advance if you are in this situation so we may help determine the best way to handle your account.

Other Policies & Service Charges

Payment Plan

If at any time you are having difficulty paying your account, we encourage you to contact our business office at (661) 371-2796, to set up a reasonable payment plan. We have many options to help during your financial hardship.

Balance Policy

Our business office will send statements regularly; if you have any questions or dispute your balance, it is your responsibility to contact our business office within 30 days. Statements will include balances due for **ALL** Centric Practice locations. If a credit occurs for a prepaid date of service, we reserve the right to reapply that payment if there is an outstanding balance on the account. Any past due accounts may be referred to an outside collection agency, and subject to interest and a negative credit rating with various credit bureaus.

_____Patient Initials

CENTRIC HEALTH

Waiver of Patient Responsibility

It is our policy to treat all patients in a fair manner related to account balances. We will not waive, fail to collect, or discount any co-pay, co-insurance, deductible, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with our Financial Hardship Policy. Please contact our business office at (661) 371-2796 for more information.

Form Completion Policy

ALL forms requiring medical review and physician signature are subject to an administrative fee of $25.00 *per form***.** This fee will be due prior to release of any completed forms.

Request for Medical Records

We require written requests for all releases of medical records. Requests for records are subject to an administrative fee of $25.00 per request plus $0.25 per page copied. We reserve the right to NOT release any records until such fees are paid.

Return Check Policy

Any check returned from the bank as unpaid, is subject to a return check fee of $25.00 per check payable by cash, money order, or credit card. We may choose to refuse future check payments on your account. In addition, we may seek all additional legal remedies provided to us under California law, including but limited to reporting your returned check to the local District Attorney's office.

Missed Appointment

We understand there may be times when you might have to miss an appointment due to other obligations or emergencies. We require at least 24 hour notice of any appointment cancellations. If a 24 hour notice is not provided it is at the discretion of the office to charge a $25 missed appointment fee. Cancelling your appointment in advance gives us an opportunity to offer medical services to another patient.

By signing this agreement:

- I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to the Centric health and Centric Health's representatives (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to :
    - File medical claims with the health plan
    - File appeals and grievances with the health plan
    - Discuss or divulge any of my personal health information or that of my dependents with any third pary including the health plan.
- I certify that the health insurance information that I provided to Centric Health is accurate as of the date set forth below and that I am responsible for keeping it updated.
- I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Centric Health are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.
- I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims.
- I understand this agreement will remain in effect until I have formally revoked in writing.
- I understand Centric Health's financial policy may be amended without prior notice.
- I acknowledge I have read and understand Centric Health's Financial Policy. A copy will be provided to me upon request.

Patient Name: _____ Date of Birth: _____

Patient or Legal Guardian Signature: _____

Relationship to patient, if other than self: _____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEGEMENT OF RECEIPT

The Centric Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

Interpreter (if applicable)