



**PATIENT REGISTRATION**

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

\_\_\_\_\_  
Last Name First Name MI Date of Birth

\_\_\_\_\_  
Address City State Zip Code

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Home Phone Cell Phone Gender at birth Female Male  
Gender Identity: \_\_\_\_\_

\_\_\_\_\_  
Social Security # Marital Status Employer Name ( ) \_\_\_\_\_  
Work Phone

**Which phone numbers may we leave a message:**

- Home
- Cell
- Work

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- White
- Hispanic
- Other: \_\_\_\_\_

**Ethnicity:**

- Hispanic or Latin
- Not Hispanic or Latin

**May we use the following methods to contact you?**

- Text
- Email: \_\_\_\_\_

**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

May we discuss billing information with responsible party

**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:**

Local Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you currently in an assisted living facility? No Yes, where? \_\_\_\_\_

**Other Providers currently involved in your care:** *Use additional sheet if necessary*

Physician Name	Phone #	Specialty	Month/Year of last visit

Emergency Contact Name	Phone #	Relationship to Patient

**Initial each**

\_\_\_\_ 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 voluntary authorize **Centric Health to provide minimal information to my emergency contacts listed** above in the event there was an emergency. I understand that a complete or portion of my medical records can be released by completing an AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form which can be obtained at our front desk.

\_\_\_\_ 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 or advised how I can obtain this at our front desk or online at CentricHealthCA.com

\_\_\_\_ I have received a copy of the **Centric Health Financial Policy** and understand my responsibility.

\_\_\_\_ "The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at [openpaymentsdata.cms.gov](http://openpaymentsdata.cms.gov)"

\_\_\_\_ **Notice and Acknowledgment of Receipt and Understanding** Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to [www.mbc.ca.gov](http://www.mbc.ca.gov)  
Email: [licensecheck@mbc.ca.gov](mailto:licensecheck@mbc.ca.gov) or call 800-633-2322

\_\_\_\_\_  
Patient or Legal Representative Signature

\_\_\_\_\_  
Patients Printed Name

\_\_\_\_\_  
Relationship to Patient if other than self

\_\_\_\_\_  
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.

#### **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 party 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: \_\_\_\_\_