Mohammad Arain MD
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Santa Maria, Ca 93454
Phone: (805) 928-2645
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PATIENT REGISTRATION

Date: ____________

First Name:____________________________________ **Last Name:** ____

Nickname:______________________ **Birthdate:** _______________ **Gender:** ____M ____F ____Other

Social Security #____ **Marital Status**: ____M ____S ____D ____W

Race:____________________ **Ethnic Group:** ________________ **Preferred Language:** ________________________

Street Address: ____

City/State/Zip: ____

Home Phone # ________________________ **Cell #** _______________________ **Work #** ________________________

Participate in Results Online: Yes No (Yes requires an email address):____________________________________

PREFERRED Contact Method: ____Phone ____Email ____Mail **Appt reminder:** ____Phone ____Email ____Mail

Name of Person financially responsible: ____

_____Self ____ Spouse ____Parent ____Guardian

Responsible party address if different: ____

Home Phone: ___________________________ **Work Phone:** _________________________________

Emergency Contact: ______________________ **Phone#:** _______________________________________

INSURANCE INFORMATION

Give your Current Insurance Card to Office to Copy:

Name of person that is the subscriber of the insurance through work or individual health plan.

Primary Insurance

Subscriber's Name ____ Date of Birth_____________________

Secondary Insurance

Subscriber's Name ____ Date of Birth_____________________

CENTRAL COAST FAMILY CARE
FINANCIAL and ADMINISTRATIVE POLICIES

Thank you for choosing Central Coast Family Care (CCFC) as your primary health care provider. Our doctors are committed to building a successful physician-patient relationship with you. Please understand that payment for services is part of that relationship. The following is a statement of our Financial Policy that outlines this binding agreement, which we require you to read and sign prior to treatment.

1. As a service to our patients, CCFC is more than happy to directly bill your insurance for services rendered, but it is our policy that the person authorizing services is ultimately responsible for payment of the service received from a CCFC Provider. CCFC Providers participate in most health plans. You are responsible for understanding your insurance health plan benefits and providing CCFC with your current address, phone number and insurance information (i.e. insurance card, subscriber information, spouse, etc.). If you do not bring your insurance card, CCFC may require payment in full at the time of the appointment. You are responsible to pay for charges incurred with terminated, outdated or not-effective insurance resulting in insurance denials for timely filing. If and when the insurance pays for the service, we will gladly refund your payment. All services not covered by your insurance plan are your responsibility.
2. All insurance Co-pays are due at the time of service. If you are not prepared to pay the appropriate fees at the time of service, the appointment may be rescheduled. Patients without insurance are required to pay all charges at the time of service, unless other arrangements are made. Cash discounts are available if paid at time of service. Central Coast Family Care accepts Cash, Checks, Visa and MasterCard.
3. All services not covered or paid by insurance such as preventative services, immunizations, copy of records, forms fees, prior authorizations, triplicate RX, etc., will be due from the patient.
4. Patients who are not on time for their scheduled appointment may be re-scheduled to a later date.
5. If you do not cancel your appointment 24 hours prior to the appointment a 25.00 NO SHOW fee will apply for standard appointments and 50.00 No Show Fee for long appointments such as pre-op visits, physicals, pap smears, new patient, etc. Frequent No Shows may result in dismissal from the practice.
6. Travel services and Travel immunizations are on a cash basis only. Insurance will not be billed for these services.
7. Patient Balances over 60 days past due may be sent for collection if arrangements are not made with the billing department. Please call 805-to discuss necessary arrangements. There is a $25.00 processing fee for all accounts sent to a collection agency and the patient may be discharged from the practice for non-payment.

Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

I have reviewed the patient information provided for accuracy and noted any changes.

I authorize treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received in writing within 30 days of statement date. I agree to pay all charges within 30 days of statement date. I agree to assign my insurance benefits to CCFC, if applicable.

I have received or have been allowed to view a copy of CCFC Privacy Notice as required by HIPAA.

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care options with: ____________________Spouse ____________________________Children : Other ________________
(Name)

I authorize my Insurance company for any insurance benefits due under my benefit plan to be paid directly to Central Coast Family Care for services provided by Central Coast Family Care.

By signing below, I am verifying that I have read each of the sections on this page. I understand each section and consent to and agree with the information stated in each section.

___________________________ ___________________________ _____________

Please Print Name Signature Date