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PATIENT REGISTRATION

Date: _____

First Name:_____ Last Name: _____

Nickname:_____ Birthdate: _____ Gender: ____M ____ F

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: ____Y____N (**Yes requires an email address**): _____

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

Person financially responsible: _____ ___ **Self ___Spouse ____Parent ___Guardian**

Responsible party address if different*:* _____

Home Phone: _____ **Work Phone: _____**

Emergency Contact: _____ **Phone#: _____**

INSURANCE INFORMATION *Please provide your current Insurance card to retain on file :*

Primary Insurance Type: _____ Policy # _____

Subscriber's Name _____D/O/B_____ Effective Date: _____

Secondary Insurance Type: _____ Policy # _____

Subscriber's Name _____D/O/B_____ Effective Date: _____

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 for you to read and sign prior to treatment.

1. As a service to our patients, CCFC is 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 all services received. CCFC Providers participate in most health plans. You are responsible for understanding your insurance benefits and providing CCFC with your current address, phone number and insurance information (i.e., insurance card, subscriber name and date of birth, etc.). If you do not bring your insurance card, CCFC may require payment in full at the time of the appointment. Insurance denials for charges that were billed with terminated, outdated or non-effective insurance are your responsibility to pay in full. 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. 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. CCFC requires a Credit Card authorization on file to pay all outstanding balances. Your Credit Card will be charged after the Insurance Explanation of Benefit is received. An additional authorization is attached and required. To make payment arrangements, call the billing office 888-348-1236
4. All services not covered or paid by insurance such as immunizations, copy of records, forms fees, prior authorizations, triplicate Rx, etc., are due from the patient at time of service.
5. Patients who are late for their scheduled appointment may be re-scheduled to a later date.
6. If you do not cancel your appointment 24 hours prior to the appointment a $50.00 NO SHOW fee will apply for standard appointments and $50.00 No Show Fee for long appointments such as pre-op visits, physicals, preventative appointments, etc. Frequent No Shows may result in discharge from the practice.
7. Patient Balances over 60 days past due may be sent for collection. Payment arrangements can be made with the billing department. Please call 888-348-1236 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 all Central Coast Family Care offices 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 and noted any changes to demographic and insurance information.
- I authorize my insurance company to pay directly to CCFC for services provided under my benefit plan(s).
- I authorize treatment of the patient named and agree to pay all fees and charges for such treatment. Charges are considered correct unless notification is received in writing within 30 days of explanation of benefits. I agree to pay all charges under my responsibility by my insurance. I agree to assign my insurance benefits to CCFC, if applicable.
- I have received or have been allowed to view a copy of the CCFC Privacy Notice as required by HIPAA.
- I authorize discussion of my medical records and diagnosis including treatment, payment, and health care options with: __Spouse __ Children __ Other/Name(s) _____

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

_____ _____ _____
Please Print Name Signature Date

CENTRAL COAST FAMILY CARE
AUTHORIZATION FOR CREDIT CARD ON FILE PAYMENT

NOTE: Your credit card information is not kept on file in this office. It is kept securely offsite, and this office does not have access to the full credit card number once it is entered into the system the first time.

AUTHORIZATION

Until further notice, I authorize Central Coast Family Care to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa Mastercard Discover A/E

Last 4 digits of my credit card: ____ ____ ____ ____

Exp. Date (mm/yy): _____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining to be paid by me. I agree that Central Coast Family Care may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $ 200.00, the billing office will attempt to call me, and if I am unreachable, my card will be charged up to $200.00/month until the remaining balance is paid.

Signature: _____ Date: _____

Printed Name: _____

Email, if you would like an email receipt: _____