CENTRAL COAST FAMILY CARE
MEDICAL ASSOCIATES OF SANTA MARIA, INC.

Laura J. Theis, M.D.
Barbara Armstrong, CNP
821 E. Chapel St, Suite 103
Santa Maria, CA 93454

PATIENT REGISTRATION

Today's Date: _____

Name: _____ Nickname: _____

If you are a minor, list your parent's names: _____

With whom does the minor live with: _____

Date Of Birth: _____Gender: _____ Marital Status: M S D W

Preferred Language: _____Race: _____ Ethnic Group: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Would you like to participate in results provided to you online: Yes No

(Yes, requires an email Address): _____

PREFFERED METHOD OF CONTACT (circle one): Phone Email Mail

Name of person financially responsible for this account: _____

Responsible Party Address: _____

Responsible Party Phone: _____

Emergency Contact: _____ Phone #: _____

Insurance Information

Please give your current insurance card to the office to make a copy

Primary Insurance Name: _____ID# _____

Secondary Insurance Name: _____ID#_____

Policy Holder: _____ Relationship: _____

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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 You are responsible to pay for charges incurred with terminated, outdated or not-effective insurance resulting in insurance denials for timely filing.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 same day cancel.40.00 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 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 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.

_____	_____	_____
Print Name	Signature	Date

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Patient Name: _____Date of Birth: _____Today's Date: _____

Referral: Who referred you to our office?

_____

Chief Complaint: Please describe the purpose of your visit today.

_____

_____

Medical History: Please list any diseases or medical conditions you have:

_____

_____

_____

Past surgeries: Please list any surgeries you have had with approximate dates performed:

_____

_____

Allergies: Please list any allergies you have to medications, adhesives, or other:

_____

_____

Medications: Please list any medications and strengths you are currently taking:

_____

_____

_____

Accidents: Please list any serious injuries you have had with the approximate age of occurrence:

_____

_____

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Patient Name: _____Date of Birth: _____Today's Date: _____

Social History:

What is your marital status?

_____ Married_____ Single _____Divorced _____ Widowed_____ Separated

What type of work do you do? _____

Do You Smoke? ____ Never ____Quit (Year Quit_____&_____ Packs per day for _____ Years)

Current Smoker_____ (packs per day _____Years_____) Smokeless Tobacco? Yes _____No_____

Do you drink alcohol? _____Never ____Occasionally _____Daily (_____drinks per day ____Per Week)

How often do you exercise? _____ How long do you exercise? _____

What type of exercise? (Please circle one) Aerobic- Strength Training -Yoga/Pilates -Walking/Running- Swimming- Biking

Diet-_____No restrictions_____ Low Salt _____Low cholesterol _____Low Fat _____Gluten Free

Family History: Please check any of the following if it runs in your family:

___Allergies ____Cancer (_____What Type?) ____Diabetes ____ Heart Disease ____Stroke _____Tuberculosis

Please tell us about your family:

Father: _____Alive _____Deceased _____Age Medical Conditions: _____

Mother: _____Alive _____Deceased _____Age Medical Conditions: _____

Brother/Sister: ____Alive ____ Deceased ____Age Medical Conditions: _____

Brother/Sister: ____Alive ____ Deceased ____Age Medical Conditions: _____

Brother/Sister: ____Alive ____ Deceased ____Age Medical Conditions: _____

Son/Daughter: ___Alive ____Decease ____Age Medical Conditions: _____

Son/Daughter: ___Alive ____Decease ____Age Medical Conditions: _____

Son/Daughter: ___Alive ____Decease ____Age Medical Conditions: _____

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Consent for use of Remote Scribe Technology

We are excited to announce the latest improvement in our practice.

In order to improve documentation of patient medical visits, your providers will be utilizing remote scribe audio and video technology. Through the use of Google glasses, a remote scribe will assist your physician, or nurse practitioner to create an accurate and detailed documentation of your medical visit.

- I have read the information provided, titled **Frequently Asked Questions** (FAQ'S) regarding remote scribe technology, and have had any questions answered by office staff.
- I understand that during sensitive parts of any examination the video will be turned off.
- I may elect at any time to withdraw my consent for continued use of remote scribe technology during an office visit, or for future visits.

Please check **one** box below:

☐ I AGREE to allow my provider to use google glasses to communicate with a remote scribe.

This consent is valid from the signing date for all future visits.

☐ I DO NOT give my consent to allow my provider to use google glasses to communicate with a remote scribe during my health care visit.

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

Date Signed: _____

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RECORDS ARE BEING REQUESTED FROM:

_____

Doctor, Hospital Or Facility

_____

Street

_____

CITY, STATE, ZIP CODE

_____

PHONE NUMBER **Fax Number**

PATIENT NAME: _____

DATE OF BIRTH: _____**PHONE NUMBER:** _____

I HEREBY AUTHORIZE MY MEDICAL RECORDS TO BE RELEASED TO

Central Coast Family Care

Laura J. Theis M.D.

Barbara Armstrong, CNP

821 E. Chapel St Suite 103 Santa Maria, CA 93454

Phone: 805-310-5330 Fax: 805-310-5339

Please check one below

☐ ALL MEDICAL RECORDS IN YOUR POSSESION: **INCLUDING**

(MENTAL HEALTH; SUBSTANCE ABUSE; HIV; AIDS; X-RAYS; OR DEVELOPMENTAL DISABLITY)

****OR****

☐ ALL MEDICAL RECORDS IN YOUR POSSESSION

For this date or date range only: _____

_____

PATIENT SIGNATURE (OR PARENT/LEGAL GUARDIAN IF PATIENT IS A MINOR) (TODAY'S DATE)