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?

____

PARENTS: What are your parents' names? (Please also note who you live with if not both parents)

____

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:

____

____

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

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Patient Name: _____________________ Date of Birth: ___________Today's Date: __________

Social History:

If you are employed, 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)

Do You play Sports? Yes or No **If yes, what sports? ____**

What are your Hobbies? ____

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: __________________________

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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)