BAY AREA I D ASSOCIATES

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name: ____Birth Date:____________________________

Social Security # _______-______-________ Home # (   ) _____________ Work # (   ) ______________ C ell (   ) ________

E-mail________________________ Preferred language: ______________________________

Marital Status: __ Single __ Married __ widowed __ Divorced __ Ethnic group: __ Non-Hispanic __ Hispanic __

Race: __ Caucasian ___ American Indian ___ Asian ___ Black ___ Other Sex M F

Employment status: ___ Employed F/T or P/T ___ Retired ___ Full Time Student ___ Not Employed

Patient's Address____

City, State, Zip ____

Employer Name ____

Referring Physician ________________________________ Phone: (   ) ____

In Case of Emergency, Contact ____________________________ Phone: (   ) _______________________________________

Cell: (   ) ___________________ Relationship to patient ____________________

Name of Pharmacy: ______________________________________Pharmacy Phone: _____________________________________

Pharmacy Address ____

Primary Insurance

Primary Insurance Company ____

Address ____

Group # ____________________________________ Policy # ____

Subscriber/Policy holder (as listed on card) ____

Patient's Relationship to Subscriber/Policyholder Self ___________ Spouse __________ Child ________Other ___________

Insured Party Date of Birth ______________________________ Social Security # ______________________________________

Employer Name ____________________________________ Work Phone ________________________ Ext. _________________

Secondary or Supplement Insurance

Secondary Insurance Company ____

Address ____

Group # _____________________________ Policy # ____

Subscriber/Policy Holder (as listed on card) ____

Patient's Relationship to Subscriber/Policyholder Self_____________ Spouse___________ Child_________ Other___________

Insured Party Date of Birth ______________________________ Social Security # ______________________________________

Employer Name ____________________________________ Work Phone ________________________ Ext. _________________

IF YOUR CARE IS A RESULT OF AN AUTO ACCIDENT OR WORKER'S COMPENSATION, PLEASE NOTIFY US

____ Auto accident ______ Worker's compensation. Also, please provide :

Claim number ___________________________ Date of Accident _______________________

Adjustor's name and phone # _______________________________________

BAY AREA ID ASSOCIATES FINANCIAL POLICY

Thank you for choosing Bay Area I D Associates as your provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

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Insurance:

We bill the plans we are contracted with. You have to pay the co-payment, co-insurance and deductible at time of service.
If your insurance requires a referral, it is your responsibility to request and bring authorization from your PCP. If you choose to be seen without referral, you are considered self-pay for that service and will be expected to pay at that time.

We need 48 hours verify insurance benefits. We may reschedule your appointment if you fail to notify the office of insurance changes or present without an ID card. If we are unable to verify your new insurance, you must pay for the visit

Medicare Patients

Please make sure you have a full understanding of your Medicare benefits and what might be your responsibility if not covered by Medicare.

We will only bill your supplement insurance once. If payment is not received within 45 days, balance will be transferred to your responsibility. If you do not have supplement, you are expected to pay your 20% at the time of service.

To diagnose a condition or evaluate how well your treatment is working, your doctor may need to have certain diagnostic tests performed. The doctor will tell you what tests why they are necessary. Before they are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN". ***Why do we ask you to sign the ABN?*** Medicare requires that we provide patients with a written notification whenever it is likely that Medicare can deny a claim, and that you will be responsible for the bill. Please ask our staff for a brochure if necessary.

Out of Network:

If you have insurance coverage under a plan in which we do not have a contract, you will be treated as a cash pay patient and will be provided documentation to assist you in filing your claim. Full payment is due at time of service.

Uninsured patients:

Payments for all services rendered are due at time of service.

Co-pay and co-insurance:

Co-pay and patient responsibility are **expected prior** to service being rendered. We are required to do so by your insurance plan. The co-payment amount is determined by your insurance policy. If you receive two different types of services on the same day, you may be asked to pay a co-pay and a coinsurance amount if required by your insurance plan.
Any service done in office might require a co pay such as an infusion, even if a physician is not seen at that time.

Deductibles:

Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. If verification of your deductible has not been met, payment of the full deductible is due at time of service.

Health Savings Accounts / Healthcare Debit Cards:

These cards carry a high deductible and you are responsible for payment of all healthcare services at the contracted rate of your health insurance, at the time of service.

Credit Card Policy:

Please review, and sign our credit card on file policy and authorization form. (The same process you would go through for hotels, rental cars etc.). This will be used within 11 months of date of service. Your credit card will be billed for any patient responsibility per your insurance explanation of benefits. At that time, we will forward to you a receipt informing you that your credit card was used for the payment.

Appointment cancellation, rescheduling and no-shows

If you do not show for your appointment, cancel or do not reschedule within 24 hours of your appointment time, you will be billed an administrative fee of $25.00, and $45.00 after the second time.

Charges for copies of medical records

You will be charged for the administrative costs of copying medical records as per State guidelines. This includes all requests for medical records, including patient's personal request. There is no charge for requests from a DR's office

Forms and letters

There is a charge of $15 per page, payable prior to these forms being completed. Please allow the office 10 business days in which to review your records for the information requested, to be completed, copied and mailed or faxed.

Outstanding balances/ Collections:

Prior to providing additional services to you, payment in full of total outstanding balances will be required. Patients with unpaid delinquent accounts or accounts which have been sent to collections and written off to bad debt will be discharged from the practice. Outstanding balances that are greater than 90 days old will be referred to an outside collection agency. Patient will be responsible for collection fees.

Payment Responsibility:

The patient or legal representative is ultimately responsible for all charges for services rendered.
"Non-covered" means that a service will not be paid under your insurance contract. We cannot offer services without expectation of payment, and if you receive non-covered services, you agree to pay at the time of receiving a statement or EOB from your insurance denying payment.
We will be happy to assist you in trying to "overturn" an adverse determination. **We will not under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered.**
If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

Professional Courtesy

Professional courtesy will not be offered in any form to our colleagues in the health related fields

Prescription Refills

Any prescription refill or new prescription not requested during the appointment will have a $25.00 charge.
There will be a $25.00 charge for any prescription requests done by phone.

Phone Appointments

If you need to discuss a healthcare issue or abnormal test results, you will be asked to schedule an appointment to see your provider.

Referral for Outside collection:

Accounts not paid according to the financial policy will be referred to an outside collection agency/attorney for further action. The patient-doctor relationship may end and the patient may be required to seek an alternative medical provider.

Anti Abuse Policy

At Bay Area I D Associates, each patient is treated with courtesy and respect. As such it is expected that patients will treat our staff in the same manner. Any verbal or physical abuse, including foul language from a patient or patient's family or friends, to our staff, will be grounds for immediate termination from the practice.

Patient Financial Responsibilities

- I understand that I am ultimately responsible for the payment for treatment and care.
- I understand that it is my responsibility to provide the practice with the most correct and updated insurance information, prior to being seen, and will be responsible for any charges incurred if the insurance provided is not correct or updated.
- I understand that I am responsible for the payment of co-pays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. I understand this is a contra-actual agreement that I have with my health plan, as the clinic also has a contra-actual agreement with my plan to collect copays, and may report to the carrier enrollees that fail to pay the copay. Payment is due at the time of services, and for my convenience, Bay Area ID Assoc accepts cash, checks, and most major credit cards.
- I understand that I may give authorization to use the credit card listed for payment in my account should my account become delinquent, or to cover a NSF check.
- I agree to abide the anti abuse policy.
- I acknowledge that I will be responsible for the payment of additional charges at the discretion of BAYIDA. These charges may include (but are not limited to):
    - $50 Charge for returned checks. I will also be required to pay with cash, money order or cashier's check.
    - $25 Charge for missed appointments without 24 hours advance notice.
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records according to State guidelines.
    - $15 per page charge for forms, and FLMA completion.
    - Any costs associated with collections, legal fees, and interest associated with collection efforts of patient balances.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian **Date:**

Waiver of Patient Authorization:

I do not wish to have information released and prefer to pay at the time of services and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Signature of Parent or Guardian Date:

Patient Authorizations and Notice of Privacy Practice acknowledgement

- By my signature below, I acknowledge that I have been granted access to the notice of privacy practice of BayArea ID Associates required by HIPAA.

  The notice of privacy practice that describes how medical information about me may be used and disclosed, and how can I get access to this information, is in a binder in the waiting area. I have been informed that I can have a copy for my use, if I desire.

  I have read, understand, and agree to the provisions of the notice of privacy practice

  ____ ______________

  Signature of Patient or Guardian **Date:**

  ____

  Witness

CONSENT FOR TREATMENT/RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I consent to the treatment necessary for the care of the patient indicated on this form. I hereby authorize Jose Prieto, M.D., P.A to furnish information to my physician and insurance carriers concerning my illness (including mental disorders, drug, or alcohol abuse and sexually transmitted disease) and treatment and/or other physicians or healthcare required to participate in my care. I assign to the physicians(s) all payments for medical services rendered to me, if I have not already paid for such services.

I understand I am financially responsible for charges. In addition, understand I am responsible for charges not covered by insurance plans in which Jose Prieto, M.D., P.A. participates and any applicable co-cays and deductibles

SIGNATURE: ______________________________________ **DATE**____________________

Credit Card Authorization
I authorize Bay area ID Associates to charge my credit card for any balance owed by me based on my insurance explanation of benefits.
Credit Card Type: ______________________________________ # ________________________________
CV _______ Expiration date ___ / ___ Card Holder Name __________________________ Zip Code _________ Signature ____ Date ________________

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations) and in case of an emergency:

Name ________________________ Relationship ________________________ Phone ( ) ________________________________

Address ____ Check if in case of emergency only: ______

Name ________________________ Relationship ________________________ Phone ( ) ________________________________

Address ____ Check if in case of emergency only: ______

Print address of where you would like billing statements and/or correspondence if different from the one listed.

____

Please indicate whether or not you would want to receive phone calls about your appointments, follow ups, test results, etc

____Yes ___ No Please print telephone number, if different from your home or cell. ______.

Can appointment reminders be left on your telephone answering machine or voice mail? ____Yes ___ No
Can other confidential messages be left on your machine? __Lab results. __ X ray results. ___ Follow up needed __Yes ___ No

Patient/Legal guardian signature ____________________ **Date** __________ **Witness** ____________________

BAY AREA I D ASSOCIATES

Outpatient Infusion Center Services, Travel Medicine, Clinic

José R. Prieto, M.D.
José E. Vasquez, M.D.
Enid V. Klauber, M.D.
Derrick D. Thiel, D.O.,
Lisa A. Washington, ARNP

PATIENT HISTORY QUESTIONNAIRE

Date of Appointment: ______________

Name: ____

Why were you referred to Infectious Disease Specialist and what is your main concern today?

____

Date of Birth: _________________ Sex: M F Marital Status: __ Single __Married __Divorced __Widowed

Race: African American Caucasian Asian Hispanic Native American Other:_____________

PAST MEDICAL HISTORY: Have you ever had any of the following? (Circle)

Glaucoma Asthma Kidney Stone Arthritis Low Back Problems
Cataracts Emphysema Kidney infections Seizures Thyroid Problems
Sinus Trouble Tuberculosis Bladder Infections Diabetes Migraine Headaches
Allergies Pneumonia Prostate Trouble Panic Attacks Skin Cancer
Angina Hepatitis Irritable Bowel Depression Phlebitis
Heart Murmur Gallstones Blood Transfusion Anxiety Sickle Cell Anemia
Stroke Stomach Ulcers High Cholesterol High Blood Pressure HIV STD's

OPERATIONS: (Give date or age) Tonsils_____ Gallbladder_____ Appendix______ Hernia_______
Hysterectomy_____ Tubal Ligation_______ Prostate_____ Breast_______ Heart_______ Other_________

OTHER HOSPITALIZATIONS: ____

CURRENT MEDICATIONS: (Give name, dosage amounts & number of times taken per day)

1. ________________________________ 6________________________________
2. ________________________________ 7.________________________________
3. ________________________________ 8.________________________________
4. ________________________________ 9.________________________________
5. ________________________________ 10.________________________________

ALLERGIES: (Medications, Food, Pollens – Describe Reaction)

1. ___________________________ 2. ___________________________ 3. ___________________________

IMMUNIZATONS: (date or age) PPD_____ Pneumonia_____Tetanus_____ Hepatitis_____ Flu Vaccine_______

WHEN DID YOU LAST HAVE THESE PERFORMED?

Cholesterol__________ Complete Physical____________ Stool for Blood ___________
For Men: Prostate Exam _____________ For Women: Pap Smear ______________ Mammogram: ________

HOUSEHOLD MEMBERS: Name: __________________ Relationship: ____________
Name: _________________ Relationship to you: _____________________

Habits: Smoke/chew tobacco (how much?) ___ Caffeine (cups)___ Alcohol (how much) _____Recr Drugs ___

Highest educational level achieved? _______________________ Occupation: _______________________

	Age	Alive	Deceased	Health Problems
Father				
Mother				
Sister / Brother				

Sister / Brother				
Sister / Brother				
Child				
Child				

FAMILY HISTORY: