Patient Registration for Bay Area Infectious Disease Associates

Patient's Name:_____ **SS #:** _____
First Name MI Last Name

Date of Birth:_____ __Male __ Female __Single __Married __Widowed __ Divorced __ Separated

Race: _____ Ethnic Group: ____ Hispanic _____ Non-Hispanic

Preferred Language: _____ English _____ Spanish _____ Other: _____

Employment Status: _____ Employed: Full Time/Part Time _____ Retired _____ Full Time Student _____ Not Employed

Street Address: _____

City/State/Zip Code: _____ **Home Phone w/Area Code:**_____

Cell Phone w/Area Code:_____ **Fax w/Area Code**:_____

Email Address: _____

Pharmacy: Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Employer: Name: _____

Address: _____

City, State, Zip: _____ Phone: _____

Insured's Name:_____**SS#:**_____

Date of Birth: _____

Street Address :_____

City/State/Zip Code:_____ **Home Phone w/Area Code:**_____

Cell Phone w/Area Code:_____ **Fax w/Area Code**:_____

Employer:_____

Address: _____

City, State, Zip: _____ Phone: _____

OPTIONAL: I authorize Bay Area Infectious Disease Associates to credit my credit card with any charges as owed by me based on insurance information.

Credit: (Circle) Discover MC Visa #_____ Exp ___/___/___

Name on card_____ CV _____ Zip _____

Responsible Party:_____ **Relationship:** __Self __Spouse __Other:_____

In case of emergency, contact:_____

Phone Number w/Area Code:_____ **Relationship to Patient:**_____

Is this work-related? __Yes __No **If yes, date of injury?**_____ **Claim #:**_____

How did this injury happen?_____

_____

Referring Physician's Name & Phone Number:_____

Referral Source: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ **Phone Number:**_____

Policy #:_____ **Group #:**_____

Insurance Company # 2:_____ **Phone Number:**_____

Policy #:_____ **Group #:**_____

If you do not have insurance, have you applied for Medicaid? __Yes __No If yes, what is the name and phone number of the social worker with whom you are working?_____

- **I hereby authorize the payment of medical benefits to Bay Area Infectious Disease Associates for services rendered as described on the Insurance Billing Form submitted either electronically or in paper form. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize Bay Area Infectious Disease Associates to release any medical information necessary to complete and process my insurance claims.**
- **I authorize Bay Area Infectious Disease Associates to treat me and use my personal health information for healthcare operations.**
- **By checking one or more of the following boxes, the health information I authorize to be released may include any of the following:**
  - **Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse**
  - **Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment**
  - **Psychiatric and/or psychological records, or evaluation and/or treatment for mental, physician, and/or emotional illness, including, narrative, summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans and/or evaluations.**
- **By my signature below I authorize Bay Area Infectious Disease Associates staff to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration form.**

>>_____ _____

>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

INFUSION SERVICES

- **Consent for Services: I request, authorize, and give consent for Bay Area Infectious Disease Associates to provide me with office infusion services and /or products. I understand that any office infusion services and/or products to be provided by Bay Area Infectious Disease Associates will be requested by my physician and will be provided under the physician's direct supervision. I understand that I have the right to choose a pharmacy of my choice.**

>>_____ _____

>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

Patient Office and Billing Policy

The following is a review of the office and billing policy of Bay Area Infectious Disease Associates. A patient's copy is provided with the new patient paperwork for the patient's retention. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Bay Area Infectious Disease Associates with current, accurate billing information at the time of check in and to notify Bay Area Infectious Disease Associates of any changes in this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, or cashier's check.

- I understand that if I fail to cancel an appointment within 24 hours or if I do not show for my scheduled appointment,

there will be a $25.00 charge.

- I understand that there is a $25.00 per form fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $15.00 per page per form fee (payable prior to completion) is required.

- I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any treatment that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to receiving my treatment. I further understand that **THE FEE I AM QUOTED IS AN ESTIMATE** based on 1) anticipated treatment to be performed and 2) current information provided to provide by my insurance carrier.

- I understand that I will be responsible for payment at time of service of any amounts due by me (co-payments/ coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with one (1) statement for any balance due after insurance payment. I further understand that if I have not made payment 30 days after receipt I may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.

- I agree to abide by the Anti Abuse Policy.

My signature below confirms that I have read the Patient and Financial Policy and I understand my financial obligation as pertains to the physicians of Bay Area Infectious Disease Associates.

_____ _____

Legal Signature Date

_____

Relationship to Patient