Eastlake Family Medical

____ M / F__
Last Name/Apellido First Name/Primer Middle Name/Medio DOB/Fecha De Nacimiento Sex/Sexo

Address ____ City _____________________ Zip Code __________
Domicilio Ciudad Codigo Postal

Marital Status: Single ___________ Married __________ SS#_________________ Driver's License _______________
Estado Civil: Soltero/a Casado/a Seguro Social Licensia de Manejo

Language/ Idioma __________________________________ Race/Raza _________________________________

Phone/Telefono ________________________Cell_________________________ Wk _____________________

Occupation/School ____
Oficio/Escuela

Preference for contact of normal results/ appointments (check one) Phone __________ Cell_________
Preferencia de contacto para resultados normales/Citas

Email/Correo Electronico ____

Emergency Contact ____________________________ Phone _________________Relationship_______________
Contacto de emergencia Telefono Relacion

Medical Insurance/Aseguranza Medica

Primary Insurance: __________________________________ Policy#/Group/Polisa/Grupo ____________________

Insurance Holder _______________________________ Employer/Trabajo _______________________________

Birthday _____________________ SS# ____________________________ Relationship_____________________
Fecha De Nacimiento Seguro Social Relacion

Secondary Insurance: __________________________________ Policy#/Group/Polisa/Grupo __________________

Insurance Holder _______________________________ Employer/Trabajo _______________________________

Receipt of Notice of Privacy Policy/ Recibo de Noticia de Poliza de Privacidad

**** You may refuse to sign this acknowledgment ** ** Usted puede negar firmar este reconocimiento ****

I, Yo ____have received a copy of this offices Notice of Privacy Practice.
. (Please print name/Por favor escriban su nombre) he recibido una copia de esta Practica de Privacidad.

____ ________________________
(Signature/Firma) (Date/Fecha)

For Office Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Policy, but acknowledgment could not be obtain because: ____ Individual refused to sign ____ Communications barriers prohibited obtaining the acknowledgement ____ an emergency situation prevented us from obtaining acknowledgment ____ Other

For Patient Only

I authorize my insurance benefits to be paid directly to Eastlake Family Medical. I am responsible for all co-payments, deductibles, and/or non covered services. I authorize the physician to release any information required by my insurance company.

Yo autorizo que los beneficios de mi asguranza sean pagados directamente a Eastlake Family Medical. Soy responsable por todos los copagos, deducibles, los servicios no cubiertos por mi aseguranza. Autorizo al doctor que mande cualquier informacion requerida por mi compania de aseguranza.

____ __________________________________
Signature (Patient or Guardian)/Firma (Paciente, Padre o Guardian) Date/Fecha

Eastlake Family Medical

Insurance Policy/Appointment Policy

Insurance coverage is a contract between the employee, employer, and insurance company. Our estimates for your percent or co-payments are based on the information you give us about your insurance and your treatment needs. As a courtesy to you, Eastlake Family Medical will send a bill to your insurance for their estimated portion if you agree to the following statements.

Insurance disclaimer: A prior authorization from your insurance or a telephone estimate is not a quote or guarantee of the portion your insurance will pay for your treatment. Payment is subject to the statues of current eligibility and plan deductibles, maximums, requirements and limitations at the time of treatment and claim processing. Procedures or treatments not covered by your plan are your responsibility to pay. Please refer to your coverage booklet or contact your insurance company.

I understand I am responsible for the entire cost of the treatment in the case that my insurance does not cover the treatment or if I have not met my deductible. I agree to pay **my copay or estimated portion at the time of visit.**

IF AT THE TIME OF YOUR APPOINTMENT, YOUR INSURANCE IS NOT ACTIVE OR IF WE ARE UNABLE TO VERIFY ELIGIBILITY, A CHARGE OF $100.00 MUST BE PAID, WHICH WILL BE REFUNDED ONCE THE CLAIM HAS BEEN PAID BY YOUR INSURANCE.

The remaining balance will be billed to you after insurance payment has been received, or if insurance has not paid after 60 days from the date the claim is submitted. The patient agrees to pay the remaining balance on the account within 30 days of the billing notification. **Any balance on the account beyond the times specified herein is subject to be sent to our collection agency, TSC SOLUTIONS. Furthermore, an additional charge of 50% of the total balance will be applied to the bill owed as a late fee. In addition, you will not be seen in our practice until the balance is paid in full.**

Appointment Cancellation policy: There will be a $50.00 cancelation fee if cancellations are not made within the following conditions:

Scheduled appointments: Must be cancelled more than 24 hours in advance.

Same-day appointments: Must be cancelled more than 4 hours in advance.

By signing this agreement, I understand that I am responsible for my account balance regardless of what my insurance pays. I hereby acknowledge my participation in all of the above agreements.

Name (printed): ____________________________________.

Signature:____ Date:____________________.