Pacific Internal Medicine Group, Inc.

PATIENT INFORMATION

Please Note: So that we may maintain the most up to date and accurate information on our patients, in addition to the face sheet presented to you at every visit, we will request that you review and update this form at least once a year.

Patient Name: First: _____ MI_____ Last _____

Social Security Number: _____ Date of Birth: _____ Sex: _____M _____ F

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____Separated ____ Life Partner

Race: ____ Hispanic/Latino ____ White ____ Black/African American ____ American Indian/Alaska Native

____ Native Hawaiian/Pacific Islander ____Decline to Specify

Ethnicity: ____ Not Hispanic/Latino ____Hispanic/Latino ____Decline to Specify

Preferred Language: ____ English ____ Spanish ____ Vietnamese ____ Chinese ____ Other: _____

Do you have any communication difficulties/special needs? ____ Hearing Loss ____ Interpreter Req'd

____ Reading Difficulty ____ Sight Impaired ____ Other: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work _____
(Required)

E-Mail: _____

Best Contact Method: _____ Home _____ Cell _____ Work _____E-Mail _____ Text to Cell

Employment Status: ____ Full-Time ____ Part-Time ____ Unemployed ____ Student ____ Disabled

_____ Retired

EMERGENCY NOTIFICATION (REQUIRED)

Name: _____ Relationship to Patient: _____

Phone: Home _____ Cell _____ Work _____

FINANCIALLY RESPONSIBLE PARTY

_____ **Same as Patient Information** (*If different, please complete section below)*

Name: First _____ MI _____ Last _____

Relationship: ____ Spouse _____ Parent _____ Guardian _____ Other (Please Specify) _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work _____

E-Mail: _____ Employer: _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Pacific Internal Medicine Group and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Pacific Internal Medicine Group of changes or update. I authorize Pacific Internal Medicine Group to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name: _____ Relationship: _____

Signature: _____ Date :_____

You may release the following information to the person named below:

____ Appointments ____ Billing Information ____ Medical Care____ Leave Message

Name: _____ Relationship: _____

Phone: Home _____ Cell _____ Work _____

AUTHORIZATION TO RECEIVE HEALTH INFORMATION VIA EMAIL

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by encrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the internet. **Initials** _____

A copy of all insurance cards, with effective date in the current year, and a driver's license/photo ID are required at check-in.

In an effort to comply with HIPAA regulations, our office requires that you present a Picture ID and your Insurance Card at every visit.

INSURANCE INFORMATION

IPA/HEALTH PLAN:

Name of IPA/Health Plan: _____ ID# _____

Membership Eligibility Date: _____

MEDICARE

Medicare ID#: _____

Do You Have Insurance Primary to Medicare? ____ Yes ____ No If Yes, Please List: _____

Medicare Supplement: _____ ID#: _____

Medicare Advantage Plan: _____ ID#: _____

MEDI-CAL

Medi-Cal ID#: _____

COMMERCIAL INSURANCE

Primary Insurance: _____ ID#: _____ Group: _____

Policy Holder Name: _____ Relationship: _____ Self ____ Spouse ____ Parent

Social Security#: _____ Policy Holder's DOB: _____ Employer _____

INSURANCE INFORMATION (CONTINUED)

COMMERCIAL INSURANCE

Secondary Insurance: _____ ID#: _____ Group: _____

Policy Holder Name: _____ Relationship: _____ Self ____ Spouse ____ Parent

Social Security#: _____ Policy Holder's DOB: _____ Employer _____

FINANCIAL AND PAYMENT GUIDELINES

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance

I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment will result in a $25.00 no show fee.

Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.

I understand that Pacific Internal Medicine Group has a contractual agreement with my insurance company that states I am required to pay for any deductibles, copayments and out of pocket share of cost. I understand that these costs must be paid at the time of service.

I understand I am responsible for notifying Pacific Internal Medicine Group of any changes to my personal information or insurance and billing information.

Pacific Internal Medicine Group or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

INFORMATIVE REQUIRED INFORMATION

Advance Directive given: _____ Yes _____ No _____ Initials

TB Risk Assessment given: _____ Yes _____ No _____ Initials

CONSENT FOR RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I further authorize and request that insurance payments be directed to Pacific Internal Medicine Group.

_____ _____

Patient Signature Date