ACCESS HEALTH SEBASTOPOL

Concierge Care

Kathleen Whisman, MD • Elizabeth Flower, MD

URGENT CARE

www.sebuc.org | (707) 509-5961

Access Health Patient Registration Form

Practice: (circle one) Urgent Care Bohemian Concierge Care Compassionate Concierge Care

PCP (Primary Care Physician):____

Patient Information: (Please use full legal name) Date:

Patient Name: ____
First: Middle: Last:

Address:____

City:____ Sate:__________ Zip Code:_____________

Home Phone:________________________ Cell Phone:__________________________

Work Phone:________________________ Email Address:_____________________________________

Date of Birth:_________________ Sex: M/F/ Other Marital Status:______________________

Social Security Number:_____________________ Driver's License Number:____________________

Emergency Contact Name: ______________________________________Phone:_____________________
(Relationship to Patient)

Address:____
City: State: Zip Code:

Guarantor Information: (List person or insured name responsible for bill)

Relationship of Guarantor to Patient: Self:__________ Spouse:_______Parent:_ _______ Other: _______

Name:____
First: Middle: Last:

Address:____

City:____ Sate:__________ Zip Code:_____________

Home Phone:________________________ Cell Phone:__________________________

Work Phone:________________________ Email Address:_____________________________________

Date of Birth:_________________ Sex: M/F/ Other Marital Status:______________________

Social Security Number:_____________________ Driver's License Number:____________________

Insurance Information: (Please allow front desk to photocopy your insurance and ID cards

If someone other than patient is the insured party, please include date of birth for claims

Primary Insurance:
Plan Name: ______________________________________ Insured's Name: ___________________________

Insured's Social Security #:__________________________Insured's Date of Birth:_____________________

Policy/ID #: _________________________Group #: ___________________Effective Date: ______________

Secondary Insurance:
Plan Name: ______________________________________ Insured's Name: ___________________________

Insured's Social Security #:__________________________Insured's Date of Birth:_____________________

Policy/ID #: _________________________Group #: ___________________Effective Date: ______________

Patient Registration Form
Disclosures and Consents

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Access Health Sebastopol or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Access Health Sebastopol is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Access Health Sebastopol Healthcare Group or the physician on my behalf

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Access Health Sebastopol Healthcare Group Patient Information Privacy Policy. I hereby authorize Access Health Sebastopol Healthcare Group or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize Access Health Sebastopol Healthcare Group representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Access Health Sebastopol Healthcare Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Access Health Sebastopol physician or his or her designee.

PATIENT SIGNATURE: ____ DATE: _______________

Patient Name: (please print) ____

GUARANTOR SIGNATURE: ____ DATE: ___________
(If different from patient)

GUARANTOR NAME: (please print) ____

Relationship to Patient: ____