FAMILY MEDICAL GROUP

911 EAST TUOLUMNE ROAD TURLOCK CA 95382
PH: 209-668-4101 FAX: 209-668-3758

PRIMARY CARE PHYSICIAN PLEASE CHECK ONE ( ) JAMES KNAPP M.D., ( ) RAFAEL SORIA M.D., ( ) ALISHA PRATT D.O., ( ) JAMES REAPE, P.A.-C, ( ) MARIE SILVA P.A.-C, ( ) KAYCEE KAHLER, P.A.-C ( ) DANIELLE PROCK, F.N.P, ( ) JAMES HOUSER, F.N.P.

PATIENT'S PERSONAL INFORMATION

Patient Name: _____
Last Name First Name initial

Date of Birth: _____ Sex(circle one): Male/Female SS# _____

Ph#: (___) _____ _____ Ph# (___) _____ _____
Circle one: Primary or Secondary Circle one: Primary or Secondary

Street Address: _____ Apt#_____

City: _____ State: _____ Zip: _____

Mailing Address (ONLY If Different): _____

Email address: _____

Marital Status: Please circle one: Single/ Married/ Divorced/ Widowed

FINANCIALLY RESPONSIBLE FOR ACCOUNT

_____ _____ _____
Last Name First Name initial

_____ Sex(circle one) : Male/Female _____ _____
Date of Birth RELATIONSHIP TO PATIENT SS#

_____ _____ _____ _____
Mailing Address APT# City State Zip

(___) _____ _____ (___) _____ _____
Primary Contact Ph# Secondary Contact Ph#

_____
SIGNATURE OF PATIENT (OR PARENT IF THE PATIENT IS UNDER 18YRS OLD) DATE

PATIENT REGISTRATION FORM

DISCLOSURE & CONSENT

FIRST NAME	M.I	LAST NAME	DATE OF BIRTH

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of may insurance benefits to Family Medical Group or the physician for services rendered to my dependent or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any copay, co-insurance, deductible or non covered benefit due that Family Medical Group is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me will be used to submit 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 Family Medical Group or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I understand the privacy risks of the mail, phone calls, and e-mails. I hereby authorize a Family Medical Group representative or my physician to mail, e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referrals, lab results, and statements from billing. I understand that I have the right to rescind this authorization at any time by notifying Family Medical Group to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICE:

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 copay, co-insurance, deductible or non-covered benefit or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREAT:

I hereby consent to evaluation, testing, and treatment as directed by my Family Medical Group physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO GUARANTOR _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(if different from patient)

GUARANTOR NAME: (PLEASE PRINT) _____

NO SHOW & CANCELLATION POLICY:

NO SHOWS: A "No-Show" is defined as an appointment that a patient does not keep, cancels or is rescheduled without a **24 hour notice**. First and Second occurrence: **$25.00 fee ($100.00** fee for complete physical or procedure appointments) Third and subsequent occurrences: **May result in dismissal from the office.**

CANCELLATIONS: Any routine appointment canceled less than 24hrs before the scheduled appointment time will be treated as a "no-show" and the above fees will apply. Multiple cancellations may result in dismissal from the office.

OTHER FEES:

I agree to pay $25.00 for any returned check for insufficient funds.

Forms requiring completion by the provider, such as disability and work release forms, require a $20.00 fee per separate form.

REQUESTS FOR MEDICAL RECORDS: We must also impose a charge for requests to have records copied. The minimum fee is $20.00 OR MORE depending upon the volume of the records to be copied. Patients with no insurance coverage are responsible for payment at the time of service.

PATIENT NAME DATE OF BIRTH

PATIENT OR PARENT SIGNATURE (IF THE PATIENT IS UNDER 18YRS OLD) DATE

Patient last name first name date of birth

INSURANCE INFORMATION PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST IN ORDER TO INSURE PROPER BILLING

PRIMARY INSURANCE NAME ID#

NAME OF POLICY HOLDER DATE OF BIRTH SS#

SECONDARY INSURANCE NAME ID#

NAME OF POLICY HOLDER DATE OF BIRTH SS#

LIST FAMILY MEMBERS THAT SHOULD BE ON SAME BILLING ACCOUNT

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP

HIPPA PRIVACY AUTHORIZATION FORM

Authorization for use of Disclosure of Protected Health Information Required by the Health Portability and Accountability Act, 45 C.F.R. parts 160 and 164

I_____

PRINT PATIENT NAME **DATE OF BIRTH**

Give Drs. Knapp,Soria, Pratt, Family Medical Group or Same Day Care @ Family Medical Group my permission to release information to the following person(s) regarding my medical treatment and care.

_____

NAME **PHONE#** **RELATIONSHIP TO PATIENT**

_____

NAME PHONE# **RELATIONSHIP TO PATIENT**

_____

NAME PHONE# **RELATIONSHIP TO PATIENT**

_____

PATIENT SIGNATURE **DATE**

Patient last name | first name | date of birth

Emergency Contact IF POSSIBLE PLEASE LIST SOMEONE NOT LIVING WITH YOU

NAME OF EMERGENCY CONTACT | HOW IS THIS PERSON RELATED TO PATIENT

(___) _____ _____ (___) _____ _____ (___) _____ _____

HOME PHONE # | CELL PHONE # | WORK PHONE #

NAME OF EMERGENCY CONTACT | HOW IS THIS PERSON RELATED TO PATIENT

(___) _____ _____ (___) _____ _____ (___) _____ _____

HOME PHONE # | CELL PHONE # | WORK PHONE #

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS | CITY | STATE

PHONE # | FAX #

US Department of Health and Human Services, National Healthcare

Quality and Disparities, Chapter 5: Enhancing Data Resources

"As the nation moves forward with enhanced health information technology and building a healthcare data infrastructure...Sub-national data, ..can inform trends on emerging measures and show promise for quality improvement. Race, ethnicity and language need, among other socioeconomic variables, continue to influence the quality of care individuals receive. For that reason, standardized information regarding these variables is a necessary component of the national healthcare infrastructure."

Dear Patients:

Due to the requirements of the National Healthcare Law, we must begin to collect the following information:

(Please circle one of the following)

Race (definitions are listed on the reverse):

Hispanic/Latino

American Indian/Alaska Native

Asian

Black/African American

Native Hawaiian/Pacific Islander

White

Decline

Country or culture of origin: _____

Primary language spoken in the home: _____

Patient Name: _____ Date of birth _____

Today's Date_____