Family Care of Santa Maria

915 E. Stowell Rd Santa Maria CA 93454

P: (805)934.5140 F:(805)934.3500

Today's Date:		PCP:	
PATIENT INFORMATION			
Last:	First:	Middle:	
Is this your legal name? Y N	If not, what is your legal name?	Maiden Name:	
Birth Date:	Age:	Sex:	S.S.N
Address:	City:	State:	Zip:
Home Phone:	Cell:	Work Phone:	
Occupation:	Employer:		
Work Address:	City	Zip Code:	
Chose clinic because / Referred by?	Other family seen here:		
INSURANCE INFORMATION			
Person responsible for bill:	Birth date:	Address (if different):	Home phone:
Are they a patient here? Y N	Is this patient covered by insurance? Y N		
Occupation:	Employer:	Address:	Phone:
Primary Insurance:	Group No.	Policy No.	Co-pay:
Subscriber/Policy Holder:	Subscribers D.O.B:	Subscriber's S.S.N	
Relationship to subscriber:			
Secondary Insurance:	Group No.	Policy No.	Subscriber:
Relationship to Subscriber:			
IN CASE OF EMERGENCY			
Name:	Relationship:	Home number:	Cell number:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize, Okerblom, Voegele and Hole to relase any information required to process my claims.

_____ _____

-Signature Date

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Name: _____ **D.O.B** _____

HAVE YOU EVER HAD PROBLEMS WITH:

___ **Headaches**
___ **Eyes, Ears or Throat**
___ **Hay Fever**
___ **Heart**
___ **Breathing**
___ **Digestion**
___ **Bowels**
___ **Neurological**
___ **Urination/Kidneys**
___ **Menstruation**
___ **Sexual Function**
___ **Depression**
___ **Arthritis**
___ **Diabetes or Thyroid**
___ **Cancer**
___ **Weight Change**
___ **Dizziness**
___ **Other**

Please Explain: _____

Family history of disease or chronic illnesses? If so, please indicate:

_____

Do you Smoke? _____ **Drink Excessively ?**_____ **Exercise Regularly?** _____

Circle Diseases in blood relatives:

* Diabetes *Stroke *Heart Disease *Cancer *Thyroid

Allergies to medications:

_____

List current medications (include strength and dose) :

_____

List prior surgeries:

_____

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NOTICE OF PRIVACY PRACTICE

The medical practice of Doctor's Robert W. Okerblom M.D., Donald J. Hole M.D., Rachel Zonca D.O., Sean Christiansen D.O., Peter D. Scott M.D and Associates have implemented policies to protect the privacy of your medical records. The following is a description of how we manage your individual medical information.

A written or electronic record of your health care is constructed at each encounter. This record may include your symptoms, examination, test results, treatment plans, outside records, and other medical information. Transcription services are often utilized. Our emplyees access this record only for legitimate medical or buisness reasons. All employees are trained in patient confidentiality procedures. Safegaurds are taken to prevent the unintended disclosure of your health and information during creation, utilization, storage and destruction. Anything that identifies a patient with their individual medical care is protected.

By law, your medical information may be shared (without your authorization) for:

1. Treatment- To facilitate your care we may share information with consulting physicians, health care entities, Public Health and legal entities , and on call physicians. For example, we will send a consulting physician relative chart notes.

2. Payment- To obtain payment from third parties, we will provide requested information to insurers. For example, your insurance company may request chart notes before payment.

3. Healthcare operations- We may supply medical information for the purpose of quality control, business activites, and other healthcare operations. For example, we may need to call your home to remind you of an appointment.

Any other disclosures of your medical record will require your written or expressed authorization. This even includes disclosures to non-dependent family members. All disclosures of your record requiring authorization will be documented.

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You have certain rights regarding your individual records, including the right to:

1. To inspect and copy your records and it's disclosures. Certain conditions like legal actions may restrict this right. Written 30 days notice is required prior to inspection, and a supervision fee may be required.

2. To request restrictions and amendments regarding your record your request must be in writing, specific, and time sensitive. We will accept or deny your request in writing. Special handling creates a burden for us and we may charge a fee.

3. To file written complaints concerning your records to our office manager.

4. To revoke in writting any prior disclosure authorizations at any time.

5. To request in writting that we communicate with you in alternative methods.

Some of the specific actions we have taken to protect your privacy include:

1. All employees with access to your medical records are trained to protect your privacy. Privacy training includes both, in the office and in the community.

2. Contracted and business associates with access to your medical records have been instructed regarding confidentiality handling of your record and have signed agreements to protect your privacy.

3. Your medical records and demographics information is never knowingly sold or otherwise released for non-medical or commercial purposes.

If there are any parts of this privacy policy you do not understand, please consult with our office manager. We are happy to address any of your questions or concerns.

A written copy of this notice is available upon request

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SERVICES NOT COVERED BY YOUR INSURANCE

Many patients request services from our office that are not covered by your health insurance provider. While we are willing to assist with these requests, they often require significant staff time and resources. Consequently, we must charge a fee to complete these services. Some examples of services not covered by your insurance are:

1. Completion of forms, DMV placard applications- $35
2. Completion of original disability forms-$35
   Subsequent disability forms-$25
3. Copying medical records for patients personal use-$25 & up
4. Completion of prescription medication prior authorizations-$35
   (approved or denied)
5. Billing printouts/Itemized receipts-$20 per patient
6. Sports physicals-$75

Please inquire in advance about your specific forms or letter of services required.

PRINT NAME:_____ DOB:_____

SIGNATURE:_____

DATE:_____

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Missed Appointment Policy for New Patient

As a new patient, if you are not able to keep your appointment please call and cancel or reschedule 24 hours in advance. By cancelling or rescheduling in advance this allows the doctor's time to be spent efficiently and for our other patients to receive timely care. If you do not cancel / reschedule and miss your appointment there will be a $50.00 charge.

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient/ Patient Respresenative **Date**

_____ _____

Patient Name **D.O.B**

_____

Relationship to Patient

ASSIGNMENT OF BENEFITS

I authorize this office to release to the beneficiary's insurance companies any information necessary to expedite insurance payment. I authorize payment directly to the provider service.

I understand that I am responsible for all charges, regardless of insurance coverage.

_____

Patient, Parent or Legal Guardian Signature

Medical Office Financial Agreement

Patient Name:_____ **DOB**:_____

Financial Responsibility and Policy Agreement

Thank you for choosing Okerblom, Voegele, and Hole MD. We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment.

1. **Patient Responsibility:** I understand that I am ultimately responsible for all fees and charges for services rendered to me or the patient named above, regardless of insurance coverage.
2. **Insurance Coverage:** As a courtesy, Okerblom, Voegele, and Hole MD will submit claims to my insurance company. I authorize the release of medical information necessary to process these claims.
3. **Co-pays and Deductibles:** All co-payments, deductibles, and co-insurance are due at the time of service.
4. **Non-Covered Services:** I agree to pay for any services that are determined by my insurance plan to be not medically necessary or otherwise not covered.
5. **Payment Terms:** If a balance is due, a statement will be sent to you. Unpaid balances over 120 days may be subject to collection actions.
6. **Returned Checks:** A fee of $25.00 will be charged for any returned checks.

A holder of this medical debt contract is prohibited by section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

I have read, understand, and agree to the provisions of this Financial Policy.

_____ _____

Signature of Patient/Guarantor **Date**

_____

Printed Name