MEDICAL CENTER OF MARIN – PATIENT INTAKE

PATIENT INFORMATION:

Today's date : ___ /___ /_____	First Name: Middle: Last:		DOB: ___ /___ /_____
Street address:		**Social Security #: _____ - _____ - _____**	Age: ❑ M ❑ F
City: ST: ZIP:	Email:	Home phone #: ( ) -	Cell phone #: ( ) -
Occupation:	Employer:	Work phone #: ( ) -	
Allergies to medication?	Primary care physician:	PCP phone #:	

HOW DID YOU HEAR ABOUT US?

If you were referred by someone specific, please provide their name so we can thank them! _____	❑ Web search engine Name:_____	☐ Your insurance plan	❑ Hospital	❑ Family or friend
		❑ Saw sign / live nearby	❑ TV commercial	❑ Other _____
	❑ Doctor's office / PCP	❑ Postcard / Direct mail	❑ Yellow Pages	

IN CASE OF EMERGENCY

Who to call:	Relationship:	Home #( )	Work #( )
Address:	City:	State:	ZIP:

PAYMENT AND INSURANCE INFORMATION

We do not bill patients; payment is due at the time of visit. We are network providers for many private insurance plans, but not all of them. If we are "in-network" for your plan, you will be responsible for your co-payment or deductible at the time of visit. As a courtesy to you, we will then complete your claim forms and bill your insurance company for the balance. Your insurance plan is a contract between you & your insurance company, & not a substitute for payment. As such, **you will be responsible for all charges not paid by your insurance company. Even if we verify your benefits, we cannot guarantee what your plan will cover, if anything. Please know we will do our best to help process your claim for you quickly & thoroughly, but the information gained from the benefits verification process is not always correct and you may owe an additional amount not specified at the time of service.** If you have an insurance plan for which we are not network providers, you will be given an itemized statement which you may submit to them for whatever reimbursement they provide, if any. Even if we are in-network providers for your insurance, your health plan is often different from your pharmacy plan. As such, if you need medications, we can either provide you with a prescription, or you can purchase the medications from us at a reasonable cost that is competitive with most pharmacy benefit plans.

The information I provided is true to the best of my knowledge. I understand I am financially responsible for all charges incurred at the time of my visit. If my insurance is accepted, I authorize my benefits be paid directly to the physician. I understand I am financially responsible for any balance my insurance doesn't cover. I also authorize Medical Center of Marin & my insurance company to release information required to process my claims.

The examination and treatment I will receive at the Medical Center of Marin is rendered on an urgent care basis only and is intended to be a temporary, short-term solution. It is not a substitute for the comprehensive care offered by primary health care providers. I understand that it is important I report any new or remaining problems to my healthcare provider. Also, my primary healthcare provider, who may obtain copies of records or test results from Medical Center of Marin, should provide all follow-up care. I have read and understand this statement.

_____ _____ _____/_____/_____

Print name Signature (☐ Check here if Parent/Guardian) Date

WHY ARE YOU HERE TODAY? Please describe any symptoms you are having:

_____

_____

Please list all medications you are currently taking:

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been given a copy of Medical Center of Marin's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. If not signed by patient, please indicate relationship: ☐ Parent or guardian of minor patient ☐ Guardian or conservator of an incompetent patient. **(Optional)** I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____or mailed to me at my address on record.

Print Name: _____ Signed: _____ Date: _____/_____/_____

OFFICE POLICIES

Welcome! We are pleased that you are here and want to let you know that we are committed to providing you with the best medical care. We also want to help you receive your maximum allowable benefits if you have medical insurance. In order to do so, we need your partnership and your clear understanding of our office and financial policies. Therefore, we ask that you read, understand and apply your signature in agreement to the following:

YOUR INSURANCE We are network providers for many private insurance carriers, and we can check your benefits for you. It is the responsibility of the patient to know what your plan will cover. If you are unable to show proof of insurance, you must pay in full at the time of the visit. If you do not have one of the above insurance plans, you will be responsible for payment in full at the time of your visit. We will provide you with an itemized statement you can submit to your insurance company for whatever reimbursement they provide, if any. Insurance is not accepted for USCIS physicals.

CO-PAYMENTS If you are a member of an insurance plan for which we are network providers, and you have a co-payment, it must be paid at the time of service prior to seeing the provider. Co-payments are collected for all office visits, including staff treatments such as blood pressure checks.

MISSED APPOINTMENTS We set aside physician time for each patient. Too often an appointment is not kept or it is canceled with too little notice to schedule another patient. Appointments that are not kept or are canceled with less than 24 hours notice will be billed a fee of $75 for new patients and $35 for returning patients.

SELF-PAY PATIENTS Payment is due at the time of your visit. **There is a $35 charge for returned checks.**

CREDIT CARDS / CHECKS We accept credit card payments using Visa, MasterCard or American Express. We accept checks if you provide the necessary information to process your check with Telecheck, including a physical address, phone number, and US driver's license.

RECORD COPIES When we receive a request for medical records, we provide a copy of recent records to other physicians at no charge. When a patient requests a personal copy of records or when a complete chart is copied, we request an advance payment of $15 plus a fee of 25¢for each page in accordance with state law. The patient may also use a copy service.

FORMS, LETTERS & REPORTS Completion of forms, letters & reports is very time consuming. Examples are accident reports, insurance applications, letters to airlines & forms for athletic participation. The charge for simple forms (less than ½ page) is $25. For documents, letters and forms longer than ½ page, the charge is $35 & up, depending on the amount of time spent and who is involved in the process. Generally we require payment before documents are released. Disability forms related to an office visit are completed at no charge.

WORKERS' COMPENSATION Please provide us with your Worker's Compensation carrier, employer and the name of the supervisor who authorized your care. By signing below, you authorize Medical Center of Marin to release any information required to process your claim, and you agree that if this claim is deemed as 'not a work injury' and denied by the insurance carrier, you are responsible for all charges with payment due & payable upon receipt of the billing statement.

MEDTOX / LABS Please be aware that all blood drawn in this office is handled by MedTox Labs. If your insurance is accepted here but does not pay for MedTox Labs, you will likely receive a large bill. Please check with your insurance company in advance.

Rx REFILLS Because we are not primary care physicians for non-workers' compensation patients, urgent care patients will generally need to be re-examined before any prescriptions can be refilled.

COLLECTIONS For balances due to Medical Center of Marin (MCoM) greater than 60 days, MCoM reserves the right to charge 15% interest per annum. An additional administrative charge of $25.00 will be assessed to you if there is a need to refer your account to a collection agency due to non-payment of any balance owed by you.

MEDICARE

We are not Medicare providers. If you have Medicare, you will need to pay for your visit in full. Medicare will not reimburse you. Secondary insurance, even if we are network providers, cannot be used to cover your visit. If you use your secondary card without notifying us of your Medicare coverage, you will ultimately be billed for your visit in full.

Please read & initial the appropriate line below:

_____ I AM NOT a Medicare recipient.

_____ I AM a Medicare recipient. I understand that Medical Center of Marin DOES NOT provide Medicare services nor do they bill Medicare for any services. I understand I am directly responsible for all charges incurred at Medical Center of Marin.

If you are a Medicare recipient, you must fill out and sign the "Medicare Opt-Out" form.
Please request the form from our Receptionist.

Signature: _____ Date: _____/_____/_____

☐ Check here if signed by Parent/Guardian