Medical Center of Marin
PATIENT INFORMATION

Chart #

Date: _____/_____/_____ Name: _____ eMail _____

SSN (Req'd!): _____-_____-_____ Home Ph: (_____) _____-_____ Cell: (_____) _____-_____ Birth Date:____/_____/_____

Address: _____City _____State _____ZIP_____

Company Name: _____Company Phone: (_____) _____-_____ Fax: (_____) _____-_____

Your Occupation:_____ Your Manager: _____ Date of Injury:_____/_____/_____

I am ☐ Right ☐ Left handed. Body Part(s) Injured: 1)_____2)_____3)_____

Describe your injury, EXACTLY HOW and WHERE IT OCCURRED: _____

_____

Have you ever injured this body part before? ☐ Yes ☐ No If Yes, give date and details: Date _____/_____/_____
Details: _____

Was this previous injury resolved? ☐ Yes ☐ No Explain: _____

Have you ever been injured on the job prior to today? ☐ Yes ☐ No
If Yes, give date and details: Date _____/_____/_____ Details: _____

Do you have more than one job? If so, please give details _____

To our Rehabilitation Patients:

1. Chiropractic or physical therapy may be prescribed for your condition and essential for your recovery.
2. The time for this treatment has been reserved specifically for you and we expect you to do the following:
    a. Arrive at the appointment time.
    b. Allow 45 minutes to 1 hour for the treatment.
    c. Follow the instructions of the doctor or the therapist handling your case. If there is a conflict, please discuss your concerns with the doctor or the therapist, we are here to help.
    d. We make every effort to see patients at their assigned treatment time. Patients who are late for their appointments cause the rest of the schedule to get backed up, and other patients have to wait as a result. Please do not be late!
3. **Please give 24 hours notice if you need to cancel or reschedule your appointment!** In the event you must cancel your appointment on short notice or you do not show up for your care, we must conclude you are not interested in your recovery and this may prompt a discharge. There is a $35 charge for missed appointments or cancellations with less than 24 hour notice. (Please initial _____)
4. If you are here for an industrial injury, please be advised your employer will be contacted if you cancel or no-show for any appointments.

_____ _____
Patient Signature Date

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: _____.

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 Aetna, Humana, ChoiceCare and the following types of Blue Cross plans (PPO/Commercial, Freedom Blue Cross PPO (NOT Medicare), and Healthy Family EPO. 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.
MEDICARE	**We are not currently 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.
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.
WORKMAN'S COMP	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.
QUEST	Please be aware that all blood drawn in this office is handled by Quest Labs. If your insurance is accepted here but does not pay for Quest Labs, you will likely receive a large bill. Please check with your insurance company in advance.
PRESCRIPTION REFILLS	We prefer that you ask your pharmacist to contact us directly via fax.
	Thank you for your cooperation and understanding!

Signature: _____ Date: _____/_____/_____

☐ Check here if signed by Parent/Guardian