PATIENT REGISTRATION FORM

Last Name: ___________________________ First: ______________________ M.I.: _______ DOB: _____/_____/_____ Gender: _____M _____F SS#: _______/______/_______ Marital Status: ______Single ______ Married ______ Widowed ______ Divorced

Ethnicity: ___________________________________ Hispanic: ______ No ______ Yes

Mailing Address: ____ Apt: _________ City: ___________________________ State: _______________ Zip Code: _______________ Email: ____ Home Ph#: _____________________________ Cell#: _________________________

Mother's Maiden Name: ____

Preferred Pharmacy/Location: ____

EMERGENCY CONTACT:

Last Name: ___________________________ First: ______________________ M.I.: _______

Relationship to Patient: ____

Home Ph#: _____________________________ Cell#: ______________________________

ANDERSON WALK-IN
MEDICAL CLINIC
WE CARE FOR YOU

ADMISSION POLICY

Anderson Walk-In Medical Clinic always accepts new patients. We are currently enrolled in Medicare, Partnership, Medi-Cal, **some** Blue Cross, Blue Shield, Aetna and Cigna networks. We accept most insurances, BUT IT IS THE PATIENT'S RESPONSIBILITY TO SEE IF WE ARE **IN**-NETWORK FOR THEIR INSURANCE. We are also listed as Preferred Providers on numerous industrial insurance company lists such as State Compensation Insurance Fund, Frank Gates and Preferred Employers. Anderson Walk-In Medical Clinic adheres to a very strict pain policy.

Anderson Walk-In Medical Clinic **does not have** any Mental Health Medical Professionals on staff. All mental health related issues are referred elsewhere for management of care.

Anderson Walk-In Medical Clinic **does provide** care for all Family Practice/General Practice medical needs.

Anderson Walk-In Medical Clinic is fully equipped to handle all **minor** injuries including: lacerations, foreign body removal, incision/drainage, and sprain/strains.

Anderson Walk-In Medical Clinic provides women's yearly exams and sports physicals. We are capable of doing pre-employment drug screens.

We perform DMV and forest service physicals, to name a couple.

You MUST **arrive 15 minutes prior** to your appointment time and 20 minutes if you are a new patient with our facility. If you do not arrive at this required time, we may need to reschedule your appointment. If you arrive late to your appointment, we will mark you as a "no show."

Anderson Walk-In Medical Clinic has a strict "no show" policy. If you "no show" **three** appointments within a **12 month period** we will no longer see you as a patient. If you are a Partnership of California patient and you no-show **three** appointments in a **six-month period** or **four** appointments in a **twelve-month period,** we will follow their policies and contact Partnership and discharge you from our practice.

We welcome you to our facility and hope that we exceed your expectations. If you have any questions or concerns, please feel free to contact the Clinic Administrator at (530) 365-4412.

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Print Patient Name

_____________________________ ____________________

Signature of Patient/Guardian **Date**

(Parent or guardian if under 18)

If our facility is not covered by your insurance, you will be required to pay 100% of the office visit. It is your responsibility to find out from their insurance company if visit is covered.

_______ ***This indicates that you have read and agree with the statement above.***

(Please Initial)

INSURANCE BILLING POLICY

Anderson Walk-In Medical Clinic offers a courtesy billing service to all patients that have private medical insurance. It is the policy of the clinic to submit medical bills to your private insurance provider the following day of your visit. Therefore, all patients must have their insurance card(s) present at the time of their first visit, and any time after that if the coverage has changed. If you do not have your medical insurance card present at the time of your visit, you will be asked to either leave a post-dated check or pay for your services with cash, check, or credit card. We are happy to courtesy-bill your insurance company for you, once you have provided our office with all required insurance information. You will be fully responsible to pay any and all deductible amounts at the time of your service, as well as any co-pay amount that your insurance provider has required from you for your plan.

Anderson Walk-In Medical Clinic does not provide any third-party billing. For example: car accident claims, personal injury claims, or any pre-existing industrial injury claims. If the medical service you are receiving today fits into any of these areas, please see the receptionist immediately.

Anderson Walk-In Medical Clinic does not currently work on a sliding fee scale, and we do not do any personal billing for someone without medical insurance. We expect payment at the time of the visit (if we are not billing an insurance provider) for services rendered. We will hold a post-dated check for up to three weeks, or we can set up an automatic electronic debit from your checking or savings account for the unpaid balance of the bill.

I acknowledge liability for all medical expenses incurred, whether the expenses are covered by my insurance provider or not. If any expenses remain unpaid for any reason, including but not limited to insurance deductible, policy limits, or plan exclusions, I agree to pay any remaining amount to Anderson Walk-In Medical Clinic. I hereby assign Anderson Walk-In Medical Clinic any and all money in which I am entitled to for medical or surgical expenses relative to the services reported herein.

Name of insurance provider: ____ * *If Medicare is your Secondary, Please tell us why:***

_____ My Spouse is still working or _____ I am a Disability Beneficiary

____

PRINT Patient Name

_____________________________________ ___________________

SIGNATURE of Patient **DATE**

(Parent or guardian if under 18)

HIPAA Authorization Form

Anderson Walk-In Medical Clinic has taken measures to protect all of our patients' private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) does allow us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, ________________________________, ***am authorizing*** the person/people listed below to obtain ***(Patient's Name)***
medical information about myself. I understand that Anderson Walk-In Medical Clinic is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:____ Date of Birth:____________________

Name:____ Date of Birth:____________________

Name:____ Date of Birth:____________________

______________________________________ ___________________

SIGNATURE of Patient **DATE**

(Parent or guardian if under 18) ***OR***

I, ________________________________, ***do not*** authorize Anderson Walk-In Medical Clinic to ***(Patient's Name)***
release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Name:

______________________________________ ___________________

SIGNATURE of Patient **DATE**

(Parent or guardian if under 18)

*Consent to Use & Disclosure of Protected Health Information **(HIPAA)***

Your protected health information will be used by Anderson Walk-In Medical Clinic or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist and she will be happy to give you a copy.

You may request a restriction on the use or disclosure of your protected health information. Anderson Walk-In Medical Clinic may or may not agree to restrict the use or disclosure of your protected health information.

If Anderson Walk-In Medical Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Anderson Walk-In Medical Clinic reserves the right to modify the Privacy Practices outlined in the notice.

I have reviewed this consent form and give my permission to Gateway Medical Services, Inc. to use and disclose my health information in accordance with federal privacy standards.

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PRINT Patient Name

______________________________ _______________

SIGNATURE of Patient **DATE**

(Parent or guardian if under 18)

NOTICE TO PATIENTS

All appointments are approximately 15 minutes in length, this typically allows for one medical issue to be addressed at each visit.

If you have multiple medical issues, we will not be able to address them in one visit.

You are welcome to schedule future appointments to address specific issues during check in or while checking out.

We strictly adhere to this policy to ensure that all patients are seen at their appointed time.

I acknowledge and understand this policy:

____

PRINT Patient Name

______________________________________ ____________________

SIGNATURE of Patient **DATE**

(Parent or guardian if under 18)