REGISTRATION INFORMATION

Today's Date ____/____/____ **Birth Date** ____/____/____

Sex: M / F **Marital Status**: M S D W **Social Security # (SSN)**:_______________________________

Patient Name ____________________________________ ______________________ ____________
(Print Last) (Print First) (MI)
Mailing Address ____
City____**State** _____________**Zip** ____________________
Ok to mail private health information? ☐ Yes ☐ No

Street Address (if different) ____
City____**State**_____________**Zip**____________________
Ok to mail private health information? ☐ Yes ☐ No

METHODS OF CONTACT

Primary Phone___________________________ ☐ Home ☐ Mobile ☐ Other_________________
Ok to leave detailed messages? ☐ Yes ☐ No
Secondary Phone_________________________ ☐ Home ☐ Mobile ☐ Other_________________
Ok to leave detailed messages? ☐ Yes ☐ No

INSURANCE INFORMATION:

Insurance Company ________________________________ **Member #**:_____________________________
Type: ☐ HMO ☐ PPO ☐ MEDICARE ☐ OTHER ☐ CASH/SELF-PAY

Subscriber's Name: ____________________________ ____________________________________
(Print Last) (Print First)
Subscriber's SSN#__________________________ **Relationship to patient**_____________________________

EMERGENCY INFORMATION: (Person to notify in case of an emergency):

Name ____ **Relationship** _________________________
Phone (   ) ___________________☐ Mark box if ok to share private health information

Name ____ **Relationship** _________________________
Phone (   ) ____________________ ☐ Mark box if ok to share private health information

OTHERS APPROVED TO SHARE PRIVATE HEALTH INFORMATION

Name ____ **Relationship** _________________________
Phone (   ) ____________________

Preferred Pharmacy ____
Address and Phone ____
☐ NCFMG may speak to my pharmacy regarding any prescriptions provided by our office.

REGISTRATION INFORMATION

Patient Name ____________________________ Date of Birth _______________________

PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I, the patient or legal guardian of patient, understand that it is my responsibility to provide a copy of my health insurance card to North Coast Family Medical Group to facilitate claim processing. If I am unable to provide this information, I understand that all services will be my financial responsibility until such information is provided.

Regardless of whether an insurance card is given or not, I acknowledge that if the patient is determined as "not eligible" under my insurance membership provisions, is not assigned to our group, and/or any specific procedures are not covered, financial responsibility for services rendered is mine. I agree to pay in full for all services rendered within 30 days of receiving a bill from the above noted physician or any healthcare provider from North Coast Family Medical Group if insurance information is not provided or covered under my plan.

I hereby authorize North Coast Family Medical Group, Inc and any of its providers to release medical information as requested by my insurance carrier. I also authorize payment by my insurance carrier directly to NCFMG. Further, I understand that all charges incurred are my responsibility regardless of insurance coverage. I understand also that some services may not be covered by my insurance carrier.

No Show Policy

PPO: I understand I will be considered "No Show" if I fail to cancel or reschedule an appointment in less than 12 hours prior to the appointment time, within a year of each circumstance. The second No Show visit will result in a $25.00 fee. The third No Show may result in disengagement at the discretion of the physician.

HMO: I understand I will be considered "No Show" if I fail to cancel or reschedule an appointment in less than 12 hours prior to the appointment time, within a year of each circumstance. The second No Show visit will result in a $25.00 fee. Continued missed appointments will result in the fee increasing in increments of $25 each time.

Acknowledgement of Privacy Practices:

By signing this form I acknowledge that I have received a copy of the North Coast Family Medical Group Notice of Privacy Practices. I also give North Coast Family Medical Group permission to contact me regarding my personal healthcare including but not limited to: medical evaluation and treatment, prescriptions, test results, medical records information, appointment scheduling and reminders, and billing issues.

NCFMG participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants within the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be accessed at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.

The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposed conducted at UCSD and at all related UC Medical Groups and UC Hospitals.

____ _____________________

Patient or Guardian Signature and Relationship Date