WELCOME TO **Health Medicine Center**

PATIENT REGISTRATION INFORMATION

1620 Riviera Ave., Walnut Creek, CA 94596 Phone: 925-935-7500
Fax: 925-935-7770 www.healthmedicinecenter.net

Last Name: First Name: Middle Name: DOB:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Soc SS#: E-mail: Drivers License #:

Male Female Minor Single Married Divorced Widowed Separated Life Partner

Occupation: Employer: Referred by?

Emergency Contact: Phone: Relationship:

Primary Insurance: Subscriber ID#: Group#:

Insurance Address: City: State: Zip:

Card Holder/Responsible Party: (If other person than yourself, please complete space below)

Soc SS# if diff: Relationship:

Home Phone: Cell Phone: Birth Date:

Secondary Insurance: Subscriber ID#: Group#:

Insurance Address: City: State: Zip:

Card Holder/Responsible Party: (If other person than yourself, please complete space below)

Soc SS# if diff: Relationship:

Home Phone: Cell Phone: Birth Date:

COPIES OF PRIMARY AND SECONDARY INSURANCE CARDS NEED TO BE ON FILE!

CONSENT FOR CARE

I, _____ hereby grant permission to the practitioners of Health Medicine Center (HMC) to perform examinations and therapeutic services, and discuss modalities & options that are considered necessary or advised for my diagnosis and care. I understand that the nature of the recommended treatments for my care will be explained to me. I can choose to comply with or deny any treatment. Practitioners who may treat me include, but are not limited to: medical doctors, nutritionists, acupuncturists, body workers, psychologists, nurses, and chiropractors. I understand that the chart of my treatments will be kept confidential under strict HIPAA rules. I authorize the practitioners of HMC to keep a collective record, which may be discussed by practitioners who have provided or may provide care for me. I further understand that I may view my medical record at any time.

AUTHORIZATION TO RELEASE INFORMATION: Health Medicine Center will release all necessary information in order to process any claims to insurance companies when requested by me, or mandated by Medicare. I understand that no personal or medical information will be released without my prior authorization and signature, unless it is requested through a subpoena.

_____ _____

Signature of Patient or Legal Guardian Date:

PRACTICE GUIDELINES AND PATIENT FINANCIAL POLICIES

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PLEASE INITIAL THE FOLLOWING IN ACKNOWLEDGEMENT OF THE POLICIES OF THE HEALTH MEDICINE CENTER

_____ Emergencies: Our staff will make every effort to receive calls and respond promptly to any emergency during regular business hours. Dr. Saputo can also be reached via e-mail at drlen@doctorsaputo.com from 9 AM to 10 PM every day of the week. If you do not receive an immediate response, please call 911, or go to the nearest emergency room.

_____ Appointments: HMC requires a minimum of 24 hours notice to cancel or reschedule an appointment as a courtesy to other patients. Fees will be charged for missed or late appointment cancellation without 24 hours notice. This is calculated at 50 % of the regular fee of the time scheduled. A pattern of missed appointments may result in discharge from the practice.

_____ Telephone Consultations: Telephone consultations are available for most conditions, except for new illnesses and symptoms that require physical examinations. Phone consultations will be charged per time needed and require credit card payment via phone. Medicare does not allow or pay for phone consultations.

_____ Financial Responsibility: The patient or responsible party will accept financial responsibility for all charges, whether or not paid by insurance. This includes all services rendered on my behalf or my dependants.

_____ Payment methods: HMC accepts cash, checks, Visa, and MasterCard.

_____ Medical records: The patient's medical record is the property of the practice. Copies of pertinent medical information are available upon 3-day prior request at a fee of $15.00. Records will be kept for the duration of time required by law.

INSURANCE / PERSONAL INJURY / WORKERS' COMPENSATION

_____ HMC is not afilliated with any insurance company. As such, HMC does not recognize a specific carrier's use of terms, co-payments, deductibles, or coinsurance. Patients are expected to pay full fees at the time of visit. HMC will submit your claim to your insurance, except to an HMO, but this will not guarantee reimbursement.

_____ Dr. Tiffany Baer is not a Medicare provider and not affiliated with any insurance. If you see Dr. Baer in our office you agree to pay in full at the end of each visit. You might ask for a copy of the superbill to submit the visit to your insurance. You cannot submit visits to Medicare, since Dr. Baer is not a Medicare provider.

_____ Medicare Patients: Dr. Saputo and Dr. Presnick are non-participating Medicare providers. Both providers will charge only the allowed fees set by Medicare. Only Dr. Saputo accepts assignment for primary Medicare patients. You still will be responsible for deductibles or any non-covered services to be paid at time of service. Dr.Presnick's patients are expected to pay at the time of service, and HMC will submit the claim to Medicare. PLEASE DO NOT SUBMIT ANY CLAIMS TO MEDICARE ON YOUR OWN.

_____ Medicare Advantage Plans and Medicare as Secondary: Dr. Saputo and Dr. Presnick will honor Medicare rates and will submit claims to the insurance, except for Kaiser Senior Advantage plans. Since these are not regular Medicare plans, we cannot guarantee reimbursement for our services. An additional form will be requires with patient's signature prior to treatment.

_____ Personal Injury / Workers' Compensation: Although HMC agrees to treat various conditions, if the cause is related to an auto or work-related accident, prior authorization by the Insurance company handling your claim is required. The authorization needs to state the exact amount of treatments and charges allowed. An additional form will be requires with patient's signature prior to treatment.

_____ TriCare as Primary: HMC is not a TriCare insurance provider and is prohibited from submitting claims to TriCare, or providing the patient with a claim form. An additional form will be requires with patient's signature prior to treatment.

I acknowledge that the above information is true and correct. I have read and understand all the terms of this policy and by my initials above and my signature below, I attest that I fully understand each item and agree to the terms above.

_____ _____

Signature of Patient or Legal Guardian Date:

_____ _____

Signature of Witness: Date:

HIPAA Policy Acknowledgment

Health Medicine Center is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

You have the right to determine whether detailed messages may be left, including any protected health information, on the phone numbers of your choice. Please provide the following numbers where we can reach you and a decision as to whether or not a message may be left.

Home Phone: _____	Confirm Appointments OK?	YES NO
	Detailed Message OK?	YES NO
Work Phone: _____	Confirm Appointments OK?	YES NO
	Detailed Message OK?	YES NO
Cell Phone: _____	Confirm Appointments OK?	YES NO
	Detailed Message OK?	YES NO
E-mail: _____	Confidential Information OK?	YES NO

Other person authorized to receive information: _____

Relationship to patient: _____ Phone: _____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Health Medicine Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____ _____ _____

Patient's Name (print) **Patient's Signature** **Date**

_____ _____

Authorized Facility Signature **Date**

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: Initials: Reason:

6 year consent form / must be updated if not seen in a 2 year period

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