CEDARS
FAMILY MEDICINE

PATIENT REGISTRATION FORM

Welcome to Cedars!

Please print these forms and bring them with you on your first visit

Patient Information

Name (Last, First, MI)			**Date**
Street Address		**City** **State**	**Zip Code**
Home Phone ☐ Preferred ( )		**Work Phone** ☐ Preferred ( )	**Cell Phone**
SSN	**Date of Birth**	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered ☐ Other _____
Race (Optional)	**Ethnicity** (Optional)		**Email Address**
Preferred Language	**Employer/ School Name and Address**		**Occupation**

How did you hear about us?

☐ Insurance Carrier ☐ Family/Friend ☐ Internet/ website ☐ Walk-In
☐ Doctor's Referral ☐ Community organization ☐ Postcard/Flyers ☐ Other

Financially Responsible Party (Primary Insurance)

Is the patient the responsible party/guarantor? ☐ Yes ☐ No (Please complete guarantor's information below)

Primary Insurance Company	**Policy #**	**Group #**	**Subscriber's SSN**
Name of Subscriber (if other than patient)	**Employer of Subscriber**		**Date of Birth**
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	**Gender** ☐ Male ☐ Female		**Phone** ( )

Secondary Insurance

Is the patient covered by a secondary/ additional insurance? ☐ Yes ☐ No (Please complete guarantor's information below)

Secondary Insurance Company	**Policy #**	**Group #**	**Subscriber's SSN**
Name of Subscriber (if other than patient)	**Employer of Subscriber**		**Date of Birth**
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	**Gender** ☐ Male ☐ Female		**Phone** ( )

Emergency Contact

Emergency Contact Name		**Relationship to Patient**
Home Phone ☐ Preferred ( )	**Work Phone** ☐ Preferred ( )	**Cell Phone** ☐ Preferred ( )

Pharmacy Info

Pharmacy Name	**Pharmacy Address**
Pharmacy Phone ( )	**Pharmacy Fax** (if known) ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability. I hereby authorize Cedars Family Medicine and its staff to use and disclose my personal health information, as necessary, for the purpose of obtaining medical treatment, facilitating the payment from third party payors for treatment and for normal business.

Patient's Name _____ **Date** _____

Patient's or Patient Representative's Signature _____

If Representative, Print Name and Relationship to Patient _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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FINANCIAL POLICY AGREEMENT

Thank you for choosing Cedars Family Medicine for your family's medical care. We are committed to providing you with quality personal health care. As a part of our professional relationship, it is important you have an understanding of our financial policy. Other than for true medical emergencies, agreement with this policy is required for all medical care.

PAYMENTS

Co-Payments Policy

- All co-payments, current balances are due and payable PRIOR to services being rendered and is required by your insurance to be paid at each visit. Patients who do not have their copayment may have their appointment rescheduled.
- Deductibles and co-insurance are due and payable at on the day of service.
- If you do not know your co-pay, we will collect a minimum fee of $15.00. Our billing department will bill or credit your account accordingly after your insurance pays their portion.

Cancellation/No Show Policy

- While understanding there may be times when you miss an appointment due to emergencies or obligations, our office requires at least 24 hours prior notice on all canceled appointments to avoid a fee of $25.00 to $75.00 (depending on the type of appointment requested).

Form Completion Policy

All forms requiring physician signature and medical review – i.e., school, daycare and camp physicals, IHSS, disability or other paperwork – will be assessed a fee for completed forms. Patient is responsible for payment.

Patient Balance Policy

- After filing claims with insurance companies, if balance is still due, will mail you a Patient Balance Statement. Payment in full is due upon receipt of this statement. If you have any questions or dispute the balance it is your responsibility to contact the billing office within 30 days. Past due accounts will be subject to a 5% monthly late fee (minimum of $5.00 per month) and may be referred to a collection agency.
- If you are not able to pay your balance in full, you must contact our billing department to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements.

INSURANCE

While the filing of insurance claims is a courtesy we extend to our patients, it is your responsibility to:

1. Bring your valid and up-to-date proof of insurance coverage and a driver's license to each appointment.
2. Complete Patient Information Form at each visit
3. Notify our office of any changes to your insurance.
4. Be familiar with your co-pay and be prepared to pay at each visit.
5. Determine if Physicians are network providers prior to your visit.
6. It is your responsibility to know coverage of your particular plan. Although we check benefits there is never a guarantee of payment.

We participate in most managed care plans and will file your insurance plan as may be necessary; however, patients are required to pay for their portion of their health plan benefits at the time services are provided.
Thank you for understanding our payment policy. Please let us know if you have any concerns.

I have read and understand the Financial Policy Agreement and agree to abide by its guidelines.

_____ _____
Patient Name Date

_____ _____
Signature of Patient/ Representative/ or Legal Guardian Date

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ADVANCE HEALTH CARE DIRECTIVE KNOWLEDGEMENT FORM

Background
In accordance with California Probate Code 4600 et seq. and Federal requirements under Title 42,clients 18 years of age and older shall receive information about Advance Health Care Directives and be informed of their right to make decisions about their medicaltreatment.

1. You have the right to give written directions about future treatment **before** you become seriously ill or unable to make healthcare decisions. This is called an "Advance Directive".

2. You have the right to accept or refuse medical or surgical treatment.

3. An office staff of the . Cedars Family Medicine Patient Registration Department will provide you with information to help you develop an Advance Directive regarding your healthcare. You are not required to make any Advance Directive about your future medical treatment. **This practice is completely voluntary.** It is entirely your choice.

4. You may consult your doctor, family, lawyer, or others before making a written Advance Directive.

5. If you decide to make an Advance Directive about future medical care it will become a part of your medical record at . Cedars Family Medicine . Photocopies of your fully executed and witnessed directive should be made for your personal records, your family members and your proxy and alternate if you have chosen them. The original or a copy should be furnished to your hospital of choice whenever you receive inpatient care.

6. You may revoke your Advance Directive at any time, in writing or simply by telling your attending physician or other healthcare provider or a witness, regardless of your physical or mental condition.

7. You are not required to have an ADVANCE DIRECTIVE in order to receive medical treatment at this practice.

I understand my rights as set forth above. Please check one of the following statements:

☐ I have received information regarding my right to make an Advance Directive.
☐ I do not have an Advance Directive. ☐ I would like receive more information.
☐ I do not have an Advance Directive and I do not want any information at this time.
☐ Yes, I do have an Advance Directive: ☐ Copy attached ☐ Copy requested by Advantage Plus Medical Center

Note: *It is the patient's responsibility to provide* Cedars Family Medicine *with a copy of any Advance Directive document (living will, health care proxy, or medical power of attorney) or other document that could affect your care, if such document(s) exist.*

_____ _____
Patient Name Date

_____ _____
Signature of Patient/ Representative/ or Legal Guardian If other than patient, relationship to patient

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For Internal Office Use Only:
☐ Information regarding Advanced Directives was provided. ☐ Verbal ☐ Written
☐ Information regarding Advanced Directives was not provided.
If the member has an Advanced Directive: ☐ Placed in the Medical Record ☐ MA Initial: _____

Comments:

Physician or Staff Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT TRACKING INFORMATION

HIPAA Notice of Privacy Practices – Acknowledgement of Receipt

I hereby acknowledge that reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is be 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 the patient, please indicate relationship:
☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient

Name of Patient: _____
Address: _____

HIPAA Notice of Privacy Practices – Acknowledgement Tracking Information

Name of Patient: _____
Address: _____

Complete the following only IF the Patient refuses to sign the Acknowledgment

Efforts to obtain:

_____
_____

Reasons for refusal:

_____
_____

For Internal Office Use Only:

Date Received: _____ Processed by: _____