

# WOODBURY MEDICAL GROUP INC.

## PATIENT'S INFO

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Male / Female \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Single / Married / Domestic Partner / Divorced / Widowed  
Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's License # \_\_\_\_\_ Occupation \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ City \_\_\_\_\_ Phone ( ) \_\_\_\_\_ - \_\_\_\_\_  
Physician you are here to see \_\_\_\_\_ How did you hear about us \_\_\_\_\_

## PRIMARY INSURANCE/FINANCIAL RESPONSIBILITY

Insurance Company \_\_\_\_\_ HMO / PPO / POS / EPO / MEDICARE / NONE  
Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_ Employer's Name \_\_\_\_\_  
Is the patient the policy holder? Yes/No \_\_\_\_\_ If No, Policy Holder's Name \_\_\_\_\_  
Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ MALE / FEMALE Relationship to patient \_\_\_\_\_  
Policy Holder's Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Driver's License # \_\_\_\_\_ Occupation \_\_\_\_\_  
Policy Holder's Address (If Different) \_\_\_\_\_

## SECONDARY INSURANCE

Insurance Company \_\_\_\_\_ HMO / PPO / POS / EPO / MEDICARE / NONE  
Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_ Employer's Name \_\_\_\_\_  
Is the patient the policy holder? Yes/No \_\_\_\_\_ If No, Policy Holder's Name \_\_\_\_\_  
Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ MALE / FEMALE Relationship to patient \_\_\_\_\_  
Policy Holder's Address (If Different) \_\_\_\_\_

## EMERGENCY CONTACT

Name of emergency contact \_\_\_\_\_ Relationship to contact \_\_\_\_\_  
Home # ( ) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_ - \_\_\_\_\_ Business # ( ) \_\_\_\_\_ - \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photo copy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that our charges will be paid by the insurance company. Insurance is an agreement between you and your insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to you bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

Patient's / Guarantor's Signature \_\_\_\_\_ Date \_\_\_\_\_



## **NOTICE OF FINANCIAL RESPONSIBILITY**

There is a possibility that your insurance will not pay for the item(s) or service(s) that are described below. They may not pay for all of your health care costs. Your insurance only pays for covered items and services stated under your benefits. The fact that your insurance company may not pay for a particular item or service does not mean that it should not be recommended or that you should not receive it. Listed below are typical items your insurance company may not cover.

### **Typical Items Not Covered:**

- Deductibles, coinsurance or copayments when you receive health care services
- Routine or yearly physical exams
- Preventative maintenance exams
- Pre-employment physical exams
- School physical exams
- Sports physical exams
- Vaccinations
- Crutches
- Orthopedic supplies (shoes, slings, splints, etc.)
- Ace bandages
- Form completion fees

**NOTE: Laboratory and Radiology Fees are separate entities from Woodbury Medical Group and so are billed separately.**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully**. Ask us to explain, if you don't understand why your insurance probably won't pay. Ask us how much these items or services will cost you in case you have to pay for them yourself or through other insurance. Also, we may not currently know or be able to find out if you are covered for certain services or items until after we have billed your insurance.

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I understand that my insurance may not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay while my insurance is making its decision. If my insurance does pay, Woodbury Medical will refund to me any payments I make to you that are due. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through other insurance. I understand I can appeal my insurance's decision.

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**Date**

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**Signature of Patient/Guarantor**

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices.

## Permission to Relay Information

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. **Some method of contact must be provided**, and as appropriate, information as to how payment will be handled.

I, \_\_\_\_\_, give my permission for Woodbury Medical Group Inc  
(Print Name of Patient)

physicians and employees to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

### Phone

Contact me regarding my appointments by telephone. YES  NO

Contact me regarding my test results by telephone. YES  NO

Leave messages on my answering machine/voice mail. YES  NO

You may use the following telephone numbers:

Work \_\_\_\_\_ Home \_\_\_\_\_ Cell Phone \_\_\_\_\_

You may leave messages with the following people (Print Names):

\_\_\_\_\_  
\_\_\_\_\_

Or

### Mail

Send mail regarding appointments, my test results or my condition and treatment to the following

Address: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Parent or Legal Guardian if Patient is a Minor)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Acknowledgement of Receipt of Notice of Privacy Practices

Woodbury Medical Group  
6340 Irvine Boulevard  
Irvine, CA 92620

Privacy Officer: 949-559-6500

Effective Date: January 8, 2007

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physicians. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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: \_\_\_\_\_

## Notice of Privacy Practices Acknowledgment Tracking Information

*Complete the following only if the Patient refuses to sign the Acknowledgment:*

Efforts to obtain: \_\_\_\_\_

Reasons for refusal: \_\_\_\_\_

\_\_\_\_\_

Employee Name: \_\_\_\_\_