Family Medicine Associates of Northridge

18350 Roscoe Blvd, Suite 600 Northridge, California 91325

Last Name: _____ **First Name:** _____

Patient Birthdate: ____/____/_____

According to HIPPA regulations of Patient Privacy Practices—How would you prefer to be contacted?

Primary: (_____) _____-_____ Do you have an email address?

Secondary: (_____) _____-_____ **Email** _____@_____

Our office will call you and may leave a message to:		
Remind you of appointments such as physicals. **Where is it okay to call?**	(Select all that apply) □ Primary □ Secondary	□ Email
Report test results or medical information regarding care. **Where is it okay to call?**	(Select all that apply) □ Primary □ Secondary	
Reply back when you leave a message. **Where is it okay to call?**	(Select all that apply) □ Primary □ Secondary	

Is it okay to leave requested information with a family member?	□ Yes	□ No
Is it okay to send your requested information by postcard to address on file?	□ Yes	□ No
If our office refers you to a specialist, may we forward medical information about you to the specialist to aid in your care?	□ Yes	□ No

Please designate emergency contacts that are authorized to discuss your health information:

Name	Relationship	Contact Info.
		*( ) -
		*( ) -
		*( ) -

*MUST BE DIFFERENT THAN OWN

Let us know if there is any other requests regarding Patient/Office/Physician contact so that we can best protect your medical information.

_____

_____

_____

Please continue to other side →

Office Billing Policies

✗ Please Read and Initial Each Below

✗_____1. **Payment is due at the time of service** – Fees for cash patients and copayments for insured patients are due at the time of your appointment. There is a $10 billing fee if you are not prepared to pay. If you are unable to pay in full, prior arrangements must be made with our billing department.

✗_____2**. $10 blood draw fee for HMO & CASH patients** – We charge this fee if you choose to have your blood drawn in the office. You may choose to go to a lab.

✗_____3. **No show** – If you are unable to keep your appointment you must contact the office at least 24 hours in advance. (If notice is not received, you will be charged a $40 No Show fee.)

✗_____4. **NSF checks** – If your check is returned from the bank unpaid (Non-sufficient funds, etc.) you will be charged an additional $35 NSF fee.

✗_____5. **Form fees** – We charge for completing forms – DMV, disability, medical leave, jury duty, letters, etc. (Average fees range from $35 - $75.)

✗_____**6. Insurance billing** – Our office will bill your insurance. **You** are responsible for any deductibles, copayments or non-covered benefits or procedures. Please read and understand your plan as we cannot be responsible for knowing the specifics about your insurance plan.
I authorize payment of medical benefits be made directly to the physician provider for services rendered.
I authorize Family Medicine Associates of Northridge to release any medical or other information necessary to process claims with my insurance companies.
I request payment of any government benefits to the party who accepts assignment.

Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act I am entitled to a copy of this office's "Notice of Privacy Practices." I may request a copy at any time. This document will outline for me the ways in which my private "protected health information" may be used and disclosed by this office, and also how I can get access to this information. I also understand that my doctor and the staff at this office will make every effort to respect and safeguard my protected health information in every way possible, and to handle it in the way I desire. I have the following rights: the right to inspect and have copies made of health information, and the right to request confidential communication when I am contacted about medical matters. I understand that full information, including some exceptions to these rights, is contained in the Notice of Privacy Practices mentioned above.
I HAVE READ THE STATEMENTS ABOVE AND BY SIGNING BELOW I ACKNOWLEDGE THAT I UNDERSTAND AND ACCEPT THEM.

Signature of Patient or Guardian: _____ Date: _____/_____/_____

Print Name or Relationship if Minor: _____