BASS
MEDICAL GROUP

PATIENT REGISTRATION FORM

LAST NAME ________________________ FIRST NAME ______________________ MI ______

DATE OF BIRTH ________/________/__________ SSN #__________________________

MAILING ADDRESS : ____
____

HOME PHONE ( ) ________________ MOBILE PHONE ( ) ________________

E-MAIL ____

Race : ________________________ Ethnicity _________________ Religion_________________

EMERGENCY CONTACT

NAME : ____ RELATIONSHIP __________________

HOME PHONE ________________________ MOBILE PHONE ______________________________

CARE TEAM

PRIMARY CARE PHYSICIAN ______________________________ PHONE _____________________

REFERRING PHYSICIAN __________________________________ PHONE _____________________

OTHER PHYSICIANS : ______________________ NAME ______________________

PHARMACY INFORMATION

LOCAL PHARMACY : _____________________________________ CITY ___________________

MAIL ORDER PHARMACY ____

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Financial Policy and Assignment Agreement for BASS MEDICAL GROUP

Office copayments and coinsurance will be collected at the time of your appointment. Our practice accepts cash, personal checks, VISA and MasterCard. You will be charged $25.00 for returned checks or credit card. *Estimated Prepayment or credit card information will be required at the time of service if you have not met your deductible and out of pocket*.

Insurance
We bill participating insurance companies as a courtesy to you. If we do not receive payment from your insurance company you will be responsible to pay the balance in full.

Assignment Agreement
I request that payment of authorized benefits be made to Bass Medical Group for any medical services rendered. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay a claim.

Missed Appointments/Late Cancellations
Broken appointments represent a cost to us, to you and inconvenience to other patients who could have been seen in the time set aside for you. *We require a 24 hour notification for cancellation or reschedule of an office appointment or there will be a $50 charge*. Excessive abuse of scheduled appointments may result in discharge from the practice. *We require a 5 business day notification to cancel or reschedule procedures or there will be a $100 charge per procedure. For missed procedures without notification there will be a $200 charge*.

Consent for Treatment of Minor
This will authorize F. Anderson Rowe, M.D., and Julia DeRenzi, PA-C to perform any necessary or routine medical treatment including examination and diagnostic procedures.

Collections
Patients with an outstanding balance of 60 days overdue must make payment arrangements prior to scheduling appointments. For accounts 90 days overdue, patients will receive a final call from our billing office and payment arrangements must be made within 10 business days. *Accounts will be sent to Collections and a 25% collection fee will be assessed, if no patient response.*

____
Patient's Name (please print) Signature Date

If Minor or Responsible Party is other than patient, please fill out below:

____
Parent/Responsible Party's Name Signature Date

____
Address Home # Alternate#

F. Anderson Rowe M.D.

5601 Norris Canyon Rd Ste 240

San Ramon, CA 94583

(925)901-1303

HIPAA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed this notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____

Date: __________________