CROWNVIEW MEDICAL GROUP, INCORPORATED

PATIENT REGISTRATION FORM

LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL_____

*Mothers name if minor Patient*_____ *Fathers name if minor patient* _____

ADDRESS_____ CITY _____ STATE_____ ZIP_____

DOB_____ SOCIAL SECUIRTY NUMBER _____-____-_____ MARITAL STATUS (S M D W) _____

SEX_____ EMAIL ADDRESS _____ Age_____

HOME PHONE _____ CELL PHONE _____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____ PHONE NUMBER (____) _____

REFERRED BY_____ ***PRIMARY CARE DOCTOR***_____

Emergency Contact _____ **Phone** _____

Relationship to you _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Carrier _____ Effective Date _____

Subscriber ID _____ Group Number _____

IF TRICARE, PLEASE ENTER SPONSOR'S NAME, DOB, AND SSN# _____

_____

SECONDARY INSURANCE

Insurance Carrier _____ Effective Date _____

Subscriber ID _____ Group Number _____

AUTHORIZATION FOR TREATMENT

I authorize Crownview Medical group, Inc. to treat and evaluate treatment including medication prescriptions. I authorize the release of any medical information necessary (including release of HIV/AIDS, mental health, Substance Abuse- to include alcohol and drugs and any reportable communicable diseases), to process a claim and hereby assign benefits payable to Crownview Medical Group, Inc. in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to my primary care doctor. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Crownview Medical Group, Inc.

PATIENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____

PATIENT/LEGAL GUARDIAN PRINT _____ DATE_____

CROWNVIEW MEDICAL GROUP, INCORPORATED

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____

Age _____ Date of Birth_____

Referred By_____

Family Physician _____Phone (_____) _____-_____

Reason for Visit_____

Date of Last Hospitalization_____

Place of Last Hospitalization_____

Reason for Last Hospitalization _____

Medication	Dosage	Frequency	How Long

Family History	Mother	Father	Sister	Brother	Other
Mental Illness					
Diabetes					
Heart Problems					
Hypertension					
Alcohol/Drug Abuse					
Tuberculosis					
Cancer					

REMARKS _____

Patient Health Questionnaire *(Continued)* **Patient Name**_____

Have you had or do you presently have problems with any of the following? Please explain.

SYMPTOMS	YES	NO	COMMENTS
Medication Allergies			
AIDS/Immune deficiencies			
Anemia			
Back (Spinal)			
Black/Bloody Stool/Urine			
Bronchitis			
Cancer or Tumors			
Chest Pain			
Chronic Constipation			
Chronic Cough			
Chronic Indigestion			
Chronis Sinus Infection			
Convulsions			
Coughing up blood			
Diabetes			
Dizziness			
Eye/Related Diseases			
Fainting Spells			
Frequent Colds			
Gall Bladder			
Genitals			
Hernia			
High Blood Pressure			
Jaundice			
Joints & Lymph Nodes			
Kidneys			
Palpitations			
Paralysis			
Pneumonia			
Poor Appetite			
Recent Weight Gain/Loss			
Skin			
Ulcers			
Other:			

CROWNVIEW MEDICAL GROUP, INCORPORATED

FINANCIAL AGREEMENT

IF YOU HAVE MEDICAL INSURANCE:

We will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the patient information form is accurate and current. If there is a change in insurance information please let us know immediately. We will submit to secondary insurance as long as we are given the correct information and we are notified that you would like this service done.

Deductibles, Co-Payments, and Coinsurance: Co-payments are constant and due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan. *Payment of the estimated deductible portion is due at the time of service.*

Authorizations: A copy of your insurance card is required at the time of the initial service. The card is descriptive and indicates whether an authorization is needed. Oftentimes, the behavioral health benefits are under a separate company and we must contact them to verify the necessity of an authorization. If a copy of the card is not on the file at the initial service and the claim is denied for "no authorization," you will be responsible for the payment.

Provider Coverage: We are able to provide you with our list of providers who participate with your insurance company. However, we are not responsible for ensuring that our provider is covered under your particular plan provision. Each insurance company has multiple plans. The provider may participate with the insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. It is ultimately your responsibility to verify coverage for your particular plan. *If the insurance company denies the claim for a plan provision, you will be responsible for the balance.*

Medical insurance coverage is a contract between you and your insurance company. WE ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. *You are ultimately responsible for the timely payment of your account.*

PAYMENT METHODS AND OTHER INFORMATION: We accept cash, check and VISA or MasterCard.

Accounts can be set up on payment plans if necessary at no additional cost.

Accounts that are past due more than 60 days will be turned over to our collection agency and reported to the Credit Bureau. Accounts that have statements returned with no forwarding address will be charged $10 and turned over to a collection agency

All late cancellations and no-shows will be billed $75 automatically. (We require 24-hour notice in advance to avoid charges.) Paperwork charges do apply and can range between $50-$200 depending on the length of report or number of pages to complete.

A SPECIAL NOTE: In situations of divorce, separation, court orders, child custody, etc., the party initiating treatment will be financially responsible for the account (including no-shows and late cancels).

CROWNVIEW MEDICAL GROUP, INCORPORATED

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy. By signing this notice I authorize Crownview Medical Group, Inc. to run my credit card on file for any/all past due balances. I further understand that I will be 100% responsible for all explained "uncovered" services.

CREDIT/DEBIT CARD INFORMATION (***Information is required***) MasterCard Visa

Card Number_____ Expiration _____

Security Code_____ Billing Zip Code _____

Patient/Legal Guardian Signature: _____ Date: _____

PERMISSION TO RELEASE INFORMATION BY TELEPHONE AND/OR IN PERSON

If you would like people designated by you to have information about your health, appointments, billing and that you are a patient in this office please complete the following information.

Any disclosure of information authorized by the patient is for the purpose of improving relationships with family and friends and to provide and maintain a family support system.

I hereby authorize CROWNVIEW MEDICAL GROUP, INC to release information limited to my general physical health and attendance in office appointments to.

_____	_____	_____
Name	Relationship	Home/Work Phone
_____	_____	_____
Name	Relationship	Home/Work Phone

Patient/Guardian Signature _____ Date _____

NON-DISCLOSURE OF INFORMATION

I do not wish knowledge of my condition to be released to anyone.

Patient/Legal Guardian Signature _____ Date _____

CROWNVIEW MEDICAL GROUP, INCORPORATED

Acknowledgement of Receipt of Notice of Privacy Practice

I hereby acknowledge that I have read a copy of this medical group's Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT (PRINT) _____ SIGNATURE_____

FOR PATIENTS UNDER THE AGE OF 18

RESPONSIBLE PARTY (PRINT) _____ RELATIONSHIP TO PATIENT_____

SIGNATURE_____ DATE_____

WITNESS_____ DATE_____

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 or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

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: _____ _____
Physician's or Authorized Representative's Signature (Date)

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

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

By: _____
Print Patient's 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.
(2-12)