

ADULT REGISTRATION (age 18 and older )

Today's Date: \_\_\_\_\_

DO YOU HAVE MEDICARE PART B INSURANCE? YES NO

If you answered YES, please **DO NOT** continue filling out this form -- see receptionist.

If you answered NO, please continue filling out this form.

**PLEASE DO NOT ABBREVIATE ANY INFORMATION**

|  |   |                    |
|--|---|--------------------|
| <u>Patient Information</u>                     |   | DOB _____ SEX: M F |
| First Name: _____ MI: ____ Last Name: _____    | Marital Status: MAR'D SING DIV WID OTH  |                    |
| Address: _____                                 | SSN: _____                              |                    |
| City: _____                                    | State: _____                            | ZIP: _____         |
| Home Phone: _____ Work Phone: _____            | Cell Phone: _____                       |                    |
| Email address: _____                           |   |                    |
| Employer Name (no abbreviations please): _____ | If Not Employed (circle one):           |                    |
| Primary Care Physician: _____                  | RETIRED UNEMP HOMEMAKER N/A<br>DISABLED |                    |

Referring Physician Information

Complete Name of Physician Who Referred You to Us: \_\_\_\_\_

Phone Number of Referring Physician: \_\_\_\_\_

**Ethnicity:**

- Hispanic or Latino                       Non-Hispanic or Non-Latino                       Declined/Undetermined

**Race:**

- 01-Black, African American                       08-American Indian, Alaska Native  
 02-Asian                       09-Native Hawaiian, Other Pacific Islander  
 03-White                       99-Declined/Undetermined

**Preferred Language:**

- EN-English                       ZH-Chinese                       Other (please specify) \_\_\_\_\_  
 ES-Spanish                       VI-Vietnamese  
 FR-French                       KO-Korean

Insurance Information

Insurance Name: \_\_\_\_\_

Ins ID# (Policy #) \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Subscriber (if other than patient)

DOB \_\_\_\_\_ SEX: M F

First Name: \_\_\_\_\_ MI: \_\_\_\_ Last Name: \_\_\_\_\_ Marital Status: MAR'D SING DIV OTH

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

Employer Name (no abbreviations please): \_\_\_\_\_ If Not Employed (circle one):

Patient's Relationship to Subscriber: \_\_\_\_\_ RETIRED UNEMP HOMEMAKER N/A

Emergency Contact

Emergency Contact's Name \_\_\_\_\_

Phone #: \_\_\_\_\_ Emergency Contact's Relationship to Patient: \_\_\_\_\_

## MVMG Financial Agreement

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### Patient's Billing Agreement PLEASE READ CAREFULLY!

- 1) I understand that if the insurance claim is denied due to incorrect information that I have provided, I will be billed and payment in full will be due immediately.
- 2) I hereby request and authorize Mountain View Medical Group physicians & personnel to deliver medical care to me.
- 3) I verify that if I am seeking primary care, I have designated a Mountain View Medical Group physician as my primary care physician with my insurance company. I understand that if the insurance company denies paying my claims because one of these doctors WAS NOT the designated PCP in effect at the time of the visit, that I am responsible for paying in full for all services provided.
- 4) If Mountain View Medical Group is contracted with my insurance company, I authorize assignment of payment directly to the doctor for services provided me. I understand that Mountain View Medical Group will file the claim with my insurance company and that I am responsible for following up with my insurance company to insure my claim is paid within 60 days of the date of service.
- 5) I understand that, under the terms of the contract of the insurance company, co-payments must be paid at every visit.
- 6) If I have insurance that Mountain View Medical Group is not contracted with, I agree to pay the bill in full at the time services are provided. I understand that Mountain View Medical Group will file a claim with my primary insurance company (except Tricare) as a courtesy, but that it is my responsibility to follow up with my insurance company to insure personal reimbursement by them.
- 7) I understand that if I have no insurance coverage, I agree to pay the balance in full at the time services are provided.
- 8) I understand that medical records are the property of the physicians of Mountain View Medical Group; however, I am entitled to copies, with sufficient advanced notice, upon my written request. I understand that there may be a charge for these copies.
- 9) I hereby authorize the release of my medical information to the insurance company concerning any illness and treatment.
- 10) I acknowledge that I can obtain a copy of the Mountain View Medical Group's Privacy Rights / HIPAA Information from the front desk upon my request.
- 11) I understand that a \$50.00 fee may be charged for all appointments missed or not canceled at least 24-hours in advance.
- 12) I understand that if my account becomes past due, Mountain View Medical Group will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees, and court costs.
- 13) I understand that I am responsible for knowing the benefits of the specific insurance plan(s) I have purchased, and that MVMG is not responsible for interpreting these benefits, or for how my insurance company(ies) process the claims. I further understand that MVMG cannot serve as an intermediary between my insurance company and myself in claims processing or claims disputes; that I must personally resolve these matters with my insurance company.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

**The following definitions for reporting race and ethnicity were created by the federal government.**

#### **Ethnicity**

|                            |  |
|----------------------------|--|
| Hispanic or Latino         | A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. <i>People of Hispanic origin may be of any race and should answer the question on race separately.</i> |
| Non-Hispanic or Non-Latino | A person not meeting the description for Hispanic or Latino.   |

#### **Race**

|   |  |
|---|--|
| American Indian or Alaska Native          | A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliations or community attachment.   |
| Asian                                     | A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand and Vietnam. |
| Black or African American                 | A person having origins in any of the black racial groups of Africa. This category may also include a person from Haiti, for example.  |
| Native Hawaiian or Other Pacific Islander | A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.   |
| White                                     | A person having origins in any of the original peoples of Europe, the Middle East or North Africa.   |