INTERNAL MEDICINE ASSOCIATES MEDICAL GROUP OF SAN DIEGO, INC.
3260 THIRD AVENUE, SAN DIEGO, CA 92103 (619) 297-3737

GENERAL PATIENT INFORMATION

DATE: _____ PHONE # _____ CELL # _____ DATE OF BIRTH _____

PATIENT'S LAST NAME: _____ FIRST: _____ INITIAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SS#: _____ AGE _____ ETHNICITY _____ RACE _____ LANGUAGE SPOKEN _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ DOMESTIC PARTNER

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____ PHONE: _____

SPOUSE NAME: _____ SPOUSE SOCIAL SECURITY NUMBER _____

PERSON TO NOTIFY INCASE OF AN EMERGENCY: _____ RELATIONSHIP: _____

EMERGENCY PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____

SUBSCRIBER'S NUMBER: _____ GROUP NUMBER: _____

RELATIONSHIP TO SUBSCRIBER: ☐ SPOUSE ☐ SELF ☐ DOMESTIC PARTNER ☐ OTHER

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____

SUBSCRIBER'S NUMBER: _____ GROUP NUMBER: _____

RELATIONSHIP TO SUBSCRIBER: ☐ SPOUSE ☐ SELF ☐ DOMESTIC PARTNER ☐ OTHER

PLEASE READ AND INTIAL AT END OF EACH STATEMENT

1. Medicare and private insurance companies may not pay for your services. They may deny the charge as an "unnecessary" service. I have been notified by this office that incase Medicare or my private insurance deems the service as "unnecessary" that I will be responsible for the payment. In most cases, I understand that Internal Medicine Associates, ("IMA"), is billing my insurance company but realize that at "times" the bill may not be paid and or delayed, in that case I will be personally responsible for payment to IMA and seek payment from the insurance company. _____
2. Internal Medicine uses outside vendors that may or may not be participating with my Health Insurance Company. I understand that it is my responsibility to know if vendors are participating or not. I understand that I am responsible to know my benefits and or restrictions. I know that I have the right to refuse any type of services or discuss treatment type with the Physician. _____
3. I authorize the release of any medical or other information necessary to process my claims. I understand that I have rights associated with the 1996 HIPPA Law. I have been given IMA's Privacy Notice and I understand that should I have any questions that I may speak with the privacy officer at IMA. _____
4. I also request payment of governments' benefits either to myself or Internal Medicine Associates who accepts assignments. I authorize payment of medical benefits to the undersign physician or supplier for services rendered today and or during my ongoing treatment with Internal Medicine. This authorization is to remain in effect until otherwise notified in writing. _____
5. **I authorize the practice to review my external prescription history** _____

By my signature I consent the above. This authorization is to remain in effect until otherwise notified in writing. I understand that I have the right to receive a copy of this consent form:

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

See Back for HIPPA Privacy Issues in regards to Billing and release of information

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3260 THIRD AVENUE
SAN DIEGO, CA 92103-5697

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THERESA R. BOHUN, M.D.
BRIAN J. LENZKES, M.D.
RAYMOND G. PIGEON, M.D.
DEANNA K. PRICE, M.D.

TELEPHONE
(619) 297-3737
FACSIMILE
(619) 297-0443

GUARANTEE OF PAYMENT CONTRACT

POLICY ON PRIOR AUTHORIZATION (OFFICE VISIT, SPECIALTY PROCEDURES, LAB TEST, IN-HOUSE SERVICES, ECT.)

It is the patient's responsibility to notify this office if your primary and /or secondary insurance plans(s) requires you to gain prior authorization before services are rendered. If authorization is not obtained and one is required by your health insurance, it will result in the claim being denied and your will be responsible for all charges incurred here at IMA or outside services that may be requested by your treating physician.

POLICY FOR PAYMENT OF MEDICAL BILLS

PAYMENT FOR ALL PROFESSIONAL SERVICES RENDERED IS THE RESPONSIBILITY OF THE PATIENT: As a courtesy to our patients, IMA will file an insurance claim on your behalf. However, your insurance might deny the claim for a numerous reasons. We will do our best to help get the claim paid, if all means are exhausted on our end, you will be ultimately responsible for payment of the insurance claim. You are responsible for all charges and services and or medical procedures/supplies not paid by your insurance carrier, subject to the conditions of our contract with your insurance company. IMA accepts many plans and is contracted with MPMG as our HMO IPO Group. If you fall under one of these plans, we will bill your insurance according to the insurance contract. If you are not eligible with the insurance at time of service or assigned to another physician, you will be billed for all services incurred at IMA. I understand that I will only be billed for my co-insurance and or co-payment if covered under the In-Network Plan or an HMO.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION REGARDING CLAIM PAYMENT

I,_____ **HEREBY AUTHORIZE**, Dr._____ to apply for benefits on my behalf for services rendered at IMA. I request payment from the insurance company provided by myself, under **Insurance Information** be made directly to the above-named physician (or in the case of Medicare Part B benefits, to myself or the party who accepts assignment.)

I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related service related to services performed at IMA or referral sources related to my medical care in order to obtain payment by my insurance company. At times I understand that my doctor will refer me out for specialty services and those doctors will be inquiring into my medical record and or need medical insurance information, I authorize IMA to release all necessary information that may be required.

I understand that by signing this contract that I agree to the above in its entirety. I understand that I have the right to revoke this authorization; I must do so in writing via US mail or in person. If authorization is revoked, I understand that IMA may not be able to bill my medical insurance and I will personally guarantee payment of services.

_____
SIGNATURE OF PATIENT OR BENEFICIARY:

_____ _____
PLEASE PRINT NAME: DATE:

_____ _____
STAFF WITNESS: DATE:

Confidential Channel Communication Request

Internal Medicine Associates Medical Group of San Diego, Inc.

3260 Third Ave San Diego CA 92103

619-297-3737 Privacy Officer: Office Administrator

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you 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, _____ (*print name*) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

(Please select all that apply. Where you list more than one communication option, please indicate which you prefer.)

☐ **Phone (no charge)**

I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine.

☐ Do ☐ Do not leave messages with any other person.

☐ **Mail: Patient to provide self-address self stamped envelope if information is to be sent to you. (Lab results, physical form, special request, etc.)**

I want you to contact me at the following address: _____

_____

☐ **E-mail (if available)**

I want you to contact me at the following e-mail address: _____

☐ **Fax (long distance calls 25 cents per page)**

I want you to contact me at the following fax number: _____

☐ **Other**

_____

_____

☐ Check here if you agree to pay for the costs associated with your request for an alternate communication channel. These costs have been explained to you.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate: Relationship:

☐ parent or guardian of patient ☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

☐ Name of Patient: _____

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CANCELLATION POLICY

Effective August 1, 2006 we ask that if you are unable to make your scheduled appointment, please notify us 24 hours in advance or you may be subject to a $25.00 cancellation fee.

Date_____

Signature_____

Witness_____

Acknowledgement of Receipt of Notice of Privacy Practices

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3260 THIRD AVE SAN DIEGO CA 92103

619-297-3737

PRIVACY OFFICER: Office Administrator

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices at my next scheduled 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: _____