NATOMAS
FAMILY PRACTICE INC.
2410 Del Paso Rd. Sacramento, CA 95834
Office: (916)928-0856 Fax:(916)928-1584

PATIENT DEMOGRAPHICS

Date _____

PATIENT FULL NAME: _____

Date of Birth: _____ **Social Security Number:** _____ - _____ - _____

EMAIL: _____

PATIENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

Patient Mobile: _____ **Home Number:** _____

***** IF PATIENT IS UNDER 18 YEARS OF AGE *****

Guarantor/Responsible Party Name: _____

Guarantor/Responsible Party SSN: _____

Relationship to Patient: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ DOB: _____ SSN: _____ - _____ - _____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER

Ins ID/Policy Number: _____ Group: _____ Effective Date: _____

Name of Secondary Insurance: _____

Subscriber's Name: _____ DOB: _____ SSN: _____ - _____ - _____

Patient Relation to Subscriber: SELF SPOUSE CHILD OTHER

Ins ID/Policy Number: _____ Group: _____ Effective Date: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone:

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FINANCIAL AGREEMENT

I authorize the release of any medical information necessary to process the claim and request that payment of any benefits be made to the undersigned physician or supplier for services described below. I understand I am financially responsible for non-covered benefits and all deductibles not covered by the authorization. Should the account be referred to an attorney for collection, the undersigned shall pay actual attorney fees and collection expenses. *I UNDERSTAND THAT NATOMAS FAMILY PRACTICE DOES NOT HAVE A MEDI-CAL (GOVERNMENT SPONSERED INSURANCE) CONTRACT. THEY WILL NOT BE BILLED, THEREFORE WE WILL NOT BE ABLE TO PROVIDE ANY SERVICES TO PATIENTS WITH MEDI-CAL.* I certify that everything above is filled out to the best of my knowledge.

It is your responsibility to notify us of any changes to your insurance, home or mailing address and phone number(s). Please return this signed form to the receptionist.

Thank you for your Cooperation.

SIGNATURE: _____ **DATE:** _____

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HIPAA FORM

(People we can speak to other than yourself)

PATIENT NAME:_____ **Date of Birth:**_____

We may release Information to:

☐ Name/ Relationship to Patient:

☐ Do not release my information to anyone

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT FOR ONE YEAR OR UNTIL TERMINATED BY ME IN WRITING.

Please select one if unable to reach you:

☐ May leave a Detailed Message including Health Information

☐ Please leave message asking me to return the Call

SIGNATURE: _____ **DATE:** _____

NATOMAS FAMILY PRACTICE INC.

Patient History Form

(This medical document is strictly confidential and will not be released without your written authorization)

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

Date of Birth:_____

MEDICAL HISTORY

AIDS/HIV	___Yes	___No	Heart Disease	___Yes	___No	Migraines	___Yes	___No
Anemia	___Yes	___No	Heart Murmur	___Yes	___No	Polio	___Yes	___No
Arthritis	___Yes	___No	Hemorrhoids	___Yes	___No	Seizures	___Yes	___No
Asthma	___Yes	___No	Hepatitis	___Yes	___No	Stroke	___Yes	___No
Bleeding	___Yes	___No	Hernia	___Yes	___No	Thyroid Disease	___Yes	___No
Cancer	___Yes	___No	High Cholesterol	___Yes	___No	Tuberculosis	___Yes	___No
Depression	___Yes	___No	High Blood Pressure	___Yes	___No	Ulcer	___Yes	___No
Diabetes	___Yes	___No	Kidney Disease	___Yes	___No	Venereal Disease	___Yes	___No
Glaucoma	___Yes	___No	Low Blood Pressure	___Yes	___No	Other:		
Heartburn	___Yes	___No	Low Back Pain	___Yes	___No	Other:		

Date of Last: **Tetanus Shot:**_____ **Sigmoidoscopy/Colonoscopy:**_____

Mammogram:_____ **Pap Smear:**_____

Previous Surgeries:	Dates:	Hospital, City, State:
_____	_____	_____

Medications (Please include prescription, over the counter, vitamins, herbal remedies, etc.):

DRUG ALLERGIES:_____

SOCIAL HISTORY

Marital Status ___ Single ___ Married ___ Seperated ___ Divorced ___ Widowed

Alcohol Use ___ Never ___ Rarely ___ Moderate ___ Daily ___ Binge

Tobacco Use ___ Never ___ Previously, but quit in _____

Drug Use ___ Never ___ Previously, but quit in _____

___ Current Use (type/frequency):_____

Education: ___High School ___Yrs ___College___Yrs ___Post Graduate ___Yrs

Current Occupation:_____ **Prior Occupation:**_____

Have you ever experienced physical, emotional or sexual abuse in your home or relationship? _____

Please name a unique or interesting fact about yourself_____

FAMILY HISTORY

Name, Age(s)	Disease	If deceased, age and cause
Father:		
Mother:		
Siblings:		
Children:		

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PATIENT NAME: _____ **Date of Birth:** _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: **If Medicare doesn't pay for D. office visit & services below, you may have to pay. Medicare does not pay for everything, even some care that your or your health care provider have good reason to think you need. We expect Medicare may not pay for all or part of the D. office visit & services below.**

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Office Visit & Services	Non Covered benefits	**$165.00** Plus cost of Services Recieved

WHAT YOU NEED TO DO NOW:

- **Read this notice, so you can make an informed decision about your care.**
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive D. office visit & services listed above.**

Note: **If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.**

G. Options: Check only one box. We cannot choose a box for you

☐ **OPTION 1:** I want the D. office visit/services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice(MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2:** I want the D. office visit/services listed above, but do not bill Medicare You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3:** I want the D. office visit/services listed above, but do not bill Medicare You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

I: Signature:	J. Date:

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CHARGES TO FILL OUT ANY PAPERWORK OR FORMS

EDD/Disability $30.00
*Extensions **$15.00**

FMLA

- 1-2 pages **$10.00**
- 3-4 pages **$20.00**
- >4 pages **$30.00**

Physical Forms/ Paperwork

- 1-2 pages **$10.00**
- 3 or more **$20.00**
- > 4 pages **$30.00**

Placard Forms/SMUD/PG&E ~ $25.00

Letters/School/Work ~ $15.00

School Forms/Paperwork

- 1-2 pages **$10.00**
- 3 or more **$20.00**

Replacement Forms/Paperwork ~ $20.00

SIGNATURE: _____ **DATE:** _____

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Referral Policy

- Generally , a new referral requires an office visit for documentation to the specialist and insurance.
- 7-10 business days are needed to obtain authorization from the insurance company. Reprocessing of a referral due to any reason will take up to another 7-10 business days.
- Reprocessing of a referral due to any reason will take up to another 7-10 business days.
- If you have a specific provider you want to see or specific request (location, sex, etc), please let your doctor know in advance.
- Please note our office does not have control over the time when you can get an appointment with the specialist. Most other offices will triage and offer appointments based on severity.
- Please place yourself on a cancellation list at the specialty office to get an appointment sooner.

***Any requests made after a referral has been completed will incur a $25 fee reprocessing fee. An additional fee of $25 will be added for each additional request with a maximum of three referrals for the same issue. ***

This new process is meant to help reduce the processing time so our patients can get timelier care.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

No-Show / Late Cancellation Policy

I, _____ have been made aware that as of May 7th 2024, there will be a No-Show/ Late Cancellation Policy in effect. I understand that I must give the office notice of the appointment cancellation at least 24 hours notice, I understand that I will be charged a fee of $50.

SIGNATURE: _____ DATE: _____