**MIGUEL GONZALEZ, MD, FCCP, FACP**
**303 S. Moorpark Rd. Thousand Oaks, Ca 91361**
**805-497-7508 Phone • 805-495-6834 Fax**

## *PATIENT INFORMATION*

**DATE:**_____**REFERRED BY:** _____

**NAME:** _____ **SEX:** M / F **MARITAL STATUS:** _____

**BIRTHDATE:** _____ **DRIVERS LIC#:** _____ **STATE LICENSE ISSUED:**_____

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

**HOME PHONE#:** _____ **WORK PHONE#:** _____ **CELL PHONE #:** _____ CELL **PROVIDER**:_____

**PREFERRED METHOD OF CONTACT**:_____

**E-MAIL ADDRESS:** _____

**EMPLOYER:** _____**OCCUPATION:** _____

**EMPLOYER'S ADDRESS:**_____

**SPOUSE/PARENT NAME:** _____ **SPOUSE/PARENT DAYTIME PHONE:** _____

**EMERGENCY CONTACT:** _____ **PHONE #:**_____

**ADDRESS:**_____

_

## *INSURANCE INFORMATION*

**INSURANCE NAME & ADDRESS:**
_____

**SUBSCRIBERS NAME:** _____ **SUBSCRIBER ID #:** _____

**SUBSCRIBERS DATE OF BIRTH:** _____ **GROUP #:** _____ **POLICY EFFECTIVE DATE:** _____

**SECONDARY INSURANCE NAME & ADDRESS:**
_____

**SUBSCRIBERS NAME:** _____ **SUBSCRIBER ID #:** _____

**SUBSCRIBERS DATE OF BIRTH:** _____ **GROUP #:** _____

## *RELEASE OF INFORMATION*

**I CONSENT TO THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING PEOPLE:**

**NAME:**_____ **RELATIONSHIP:**_____

**NAME:**_____ **RELATIONSHIP:**_____

**NAME:**_____ **RELATIONSHIP:**_____

**NAME:**_____ **RELATIONSHIP:**_____

SHOULD YOU CHOOSE TO LEAVE THIS SECTION BLANK, WE WILL NOT BE ABLE TO GIVE OUT ANY INFORMATION OR TO DISCUSS YOUR MEDICAL CONDITION WITH ANYONE.

**BY MY SIGNATURE BELOW, I ATTEST THAT THE ABOVE IS TRUE AND CORRECT. SHOULD THIS INFORMATION CHANGE, IT IS MY RESPONSIBILITY TO MIGUEL GONZALEZ, MD OF THOSE CHANGES IN A TIMELY MANNER.**

**PATIENT SIGNATURE:** _____

.

**MIGUEL A. GONZALEZ, M.D., FCCP, FACP**

Thank you for allowing us to assist you on the road to better health! We are looking forward to seeing you. Please complete the enclosed papers and bring them with you at the time of your appointment along with your insurance cards, recent laboratory results and x-rays. Please be sure to bring your payment in full with you.

## FINANCIAL POLICY

- We are committed to providing you, our patients, with quality care at a reasonable cost. It is our hope that you will understand that our credit and collection policies are a necessary part of assuring the financial resources required to maintain our health care services for our patients and the community.
- Payment for all services are due at the time of the visit. We are not contracted with any insurance company.
- Charges for medical services are due and payable at the time the services are rendered. If you have health insurance, it should be understood that this is an agreement between you and your insurance to pay certain amounts for your medical care. We are pleased to bill your insurance for you as a one time courtesy; however, you are ultimately responsible for the payment of your bill, regardless of the status of your insurance claim.
- Insurance companies have a schedule of fees which they will pay for medical services. Your doctor's fees may be more or less than the schedule of your insurance company. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. You should be aware that you are still responsible to the doctor for your account, irrespective of your insurance company's fee schedule. Remember that insurance benefits are not a guarantee of payment.
- Should your account be sent to collections, you will be charged a $25 transfer to collection fee as well as further collection fees assessed by the collection agency.
- If you have any questions, problems or concerns, please call our billing department Monday-Friday, between the hours of 8:00 AM and 3:00 PM.

## NO SHOW POLICY

- We will contact you by phone using an automated service to remind you of your appointment one day prior to your scheduled appointment time. We require 24 hour notice of cancelled appointments, barring unforeseen emergencies. **Should you miss a scheduled appointment and you were reminded, there will be a $150 no show fee.**

## FEES FOR SERVICES NOT COVERED BY INSURANCE

- Should you require an MRI, CT, ultrasound or any other service that your insurance requires a prior authorization for, there is a fee of $25 for each authorization that we will obtain on your behalf.
- Should you need a medication that requires a prior authorization there is a fee of $25 for each authorization that we will obtain on your behalf.
- Should you need forms filled out for any reason, such as Life insurance, patient assistance, utilities, disability, DMV, etc, there is a fee for each form depending on the length and type of form.

## ANCILLARY SERVICES, LABORATORY & MEDICATIONS

Please note **some of the labs or other facilities that we refer you to may NOT be contracted with your insurance company.** The charges for x-rays and outside laboratory testing are totally separate from our charges and will not be reflected on our bill. It is your responsibility to know which facilities are contracted with your insurance carrier to ensure proper reimbursement. We will help you with this whenever possible but the final responsibility is yours. Please call the number on your insurance card for more information. Our office does not bill your insurance for any outside lab service or any other service performed outside our office. Any and all billing questions must be directed to that provider of service.

I have read and understand the financial and no show policies of Miguel Gonzalez, MD.

**PRINT NAME:**_____**DATE OF BIRTH:**_____

**SIGNATURE:**_____**DATE:**_____

**MIGUEL GONZALEZ, M.D. F.C.C.P.**
**PROFESSIONAL CORPORATION**

**INTERNAL MEDICINE, PULMONARY DISEASES & CRITICAL CARE · AMERICAN BOARDS OF INTERNAL MEDICINE AND PULMONARY DISEASES**

**303 S. MOORPARK ROAD THOUSAND OAKS, CA 91361 (805) 497-7508 · FAX (805) 495-6834**

# HIPAA DISCLOSURES

*The Federal Government has established a new law known as HIPAA (Health Insurance Portability & Accountability Act). This law seeks to formalize privacy rights that have been respected by the health care profession for many years.*

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan, and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We have prepared a detailed notice describing how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. This notice will be offered to you at your office visit and available for you to read at any time in our office.

Following is a brief summary of your rights:

- NOTICE – The right to be informed about uses and disclosures of PHI.
- CHOICE – The right to deny permission of certain uses and disclosures of PHI.
- INSPECTION – The right to review your PHI.
- AMENDMENT – The right to request changes to PHI that is inaccurate or incomplete.
- AUDIT – The right to receive an audit or accounting of certain classes of disclosures of your PHI.
- REDRESS – The right to complain about perceived violations of your privacy and to have these complaints taken seriously.

*We have taken formal measures to comply with this law, and as always, our first concern is to provide each patient with the highest quality medical care possible.*

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**MIGUEL GONZALEZ, M.D. F.C.C.P.**
**303 S. MOORPARK ROAD THOUSAND OAKS, CA 91361 (805) 497-7508 · FAX (805) 495-6834**

Privacy Officer: Office Manager

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current Notice will be available in the reception area and that I may request a copy of any amended Notice of Privacy Practices at any time.

PATIENT/GUARDIAN NAME: _____

PATIENT ADDRESS: _____

SIGNATURE: _____

DATE: _____

If not signed by the patient, please indicate:

Relationship to patient:

( ) Parent or guardian of minor patient
( ) Guardian or conservator of an incompetent patient
( ) Beneficiary or personal representative of deceased patient.

Name of Patient: _____

**FOR OFFICE USE ONLY:**
Complete the following only if the Patient declines to sign the Acknowledgement:

Efforts to obtain:_____

Reasons for declining:_____