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:**_____

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. I ALSO AGREE TO RECEIVE OCCASIONAL E-MAILS FROM DR. GONZALEZ WITH INFORMATION ON RESTORING AND MAINTAINING MY OPTIMAL HEALTH.

PATIENT SIGNATURE: _____**DATE:**_____

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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 co-pay 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.
- All co-pays and deductibles are due at the time of the visit.
- Charges for medical services are normally 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; however, you are ultimately responsible for the payment of your bill, regardless of the status of your insurance claim. Please be aware that if you have a secondary insurance plan, we will bill it for you as a courtesy once, and if no payment is received within 60 days, the balance will be transferred to you. Also, do not assume that just because you have a secondary insurance, that you will not have to pay a co-insurance.
- 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.
- We accept Medicare payment, however, Medicare does have an annual deductible and co insurance amounts that you are responsible for. Your secondary insurance is billed as a courtesy to you. If your secondary plan does not pay any deductible or co-insurance amount you are responsible for that balance.
- It is your responsibility to inform the office of any insurance changes at the time of service. You must bring your insurance card so the card can be copied and put on file and the current insurance billed. If we receive a denial stating your coverage has been terminated you will receive a bill and it is your responsibility to contact the office within 5 days of receipt of that statement and provide current insurance information and or make payment arrangements. You must respond within this time frame due to timely filing requirements by each carrier.
- It is your responsibility to provide the correct address for any billing or correspondence that may be sent to you.
- If unusual circumstances should make it impossible for you to meet our financial policy terms, we invite you to call and personally discuss that matter with our billing department. This will avoid misunderstandings and enable you to keep your account in good standing. Except when special arrangements have been made, accounts 90 days past due may be referred to a collection agency. This may terminate the physician patient relationship.
- 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. This service keeps a log of who they called and the disposition of the call.
- 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 $100 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. This is not covered by your insurance and is payable before we initiate the prior authorization process. Medicare patients are not required to get prior authorization for these studies therefore this fee is not applicable to those patients.

- 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. This is not covered by your insurance and is payable before we initiate the prior authorization process.
- Should you need forms filled out for any reason, such as Life insurance, patient assistance, utilities, disability, DMV, etc, there is a $25 fee for each form that needs to be completed. This is not covered by your insurance and is payable when you present the form to our office.

ANCILLARY SERVICES, LABORATORY & MEDICATIONS

Please note Miguel Gonzalez, MD may be contracted with your insurance company **but 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. Also some of the medications that we prescribe for you may not be on your insurance plan; in that instance, you will have to check with your insurance company to see what is covered.

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. Diagnosis codes are provided by the nursing staff for any outside service not the billing department. Any questions related to a diagnosis for any outside services should be addressed to our office nurse.

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

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

SIGNATURE:_____**DATE:**_____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS OR INFORMATION RELEASE REQUIRED ON ALL PATIENTS

I, the undersigned, authorize payment of my medical benefits to Miguel Gonzalez, MD for any services furnished to me by the above physicians. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

SIGNATURE:_____**DATE:**_____

NAME (PLEASE PRINT):_____**DOB:**_____

MEDICARE LIFETIME SIGNATURE ON FILE (REQUIRED ON ALL MEDICARE PATIENTS)

I request that payment of authorized Medicare benefits be made on my behalf to Miguel Gonzalez, MD for any services furnished to me by the above physicians. I authorize any holder of medical information about me to release to the health care financing administration agents any information needed to determine these benefits or the benefits payable for related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the allowable determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the allowable determination of the Medicare carrier.

SIGNATURE:_____**DATE:**_____

NAME (PLEASE PRINT):_____**DOB:**_____

MEDI-GAP INSURANCE ASSIGNMENT (REQUIRED FOR ALL PATIENTS WITH MEDICARE AND A SECONDARY INSURANCE ELECTRONICALLY BILLED BY MEDICARE)

I request that payment of authorized Medi-Gap benefits be made either to me, or on my behalf to Miguel Gonzalez, MD for any services furnished to me by the above physician. I also authorize any holder of medical information about me to release to my insurer any information needed to determine these benefits payable for related services.

SIGNATURE:_____DATE:_____

NAME (PLEASE PRINT):_____DOB:_____

MIGUEL GONZALEZ, MD, FACP, FCCP
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.

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Privacy Officer: Office Manager

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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:_____