ORTHOPEDIC MEDICAL GROUP OF SAN DIEGO, INC.

___ Richard F. Santore, MD (2)
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3750 Convoy Street Suite 201
San Diego, CA. 92111
(858) 278-8300
(858) 278-1708

___ Update _____
___ New Info _____

For Office Use Only

REGISTRATION INFORMATION

(_) PVT (_) PPO (_) M-CAL (_) M-CARE (_) HMO (_) TRICARE (_) POS Date _____

Patient's Full Name:

_____
Last First Middle

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

Home Phone:(____)_____ Work Phone: (____)_____

Mobile:(____)_____ E-Mail: _____

Marital Status: _____ Date Of Birth: _____ Age: _____ Sex: _____ Social Security #_____

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

Pharmacy Name: _____ Number/Address_____

Referred By: _____ Address: _____ Telephone #: _____

Primary M.D.: _____ Address: _____ Telephone #: _____

Insured Name: _____ Relationship to Patient: _____

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

Home Telephone: (____)_____ Date of Birth: _____ Social Security #: _____

Employer: _____ Work Telephone: (____)_____

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

Primary Insurance: _____ ID#: _____ Group #: _____

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

Telephone #: (____)_____ Copay$:_____

Secondary Insurance: _____ ID#: _____ Group #:_____

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

Telephone #: (____)_____ Copay $: _____

Spouse/Partner:_____ Telephone #: (_____)_____

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

Emergency Contact: _____ Telephone #: (_____)_____

Have you ever been seen in this office before? Yes (__) No (__) By: _____ When: _____

I understand that patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments to the doctor. I accept financial responsibility for all charges incurred. I understand that statements are due when presented to me by Orthopedic Medical Group or when transferred to me by my insurance carrier and that a late payment charge of 1% per month applies to overdue balances. If my account has to be referred for outside collections I will be charged a service charge.
AUTHORIZATION: I hereby authorize payment directly to Orthopedic Medical Group of San Diego, Inc. for medical services by that group, and to release any information acquired in the course of my examination or treatment to my insurance company.

Patient's/Guardian's Signature **X**_____ Witness Signature _____

ELIGIBILITY GUARANTEE

I, _____, hereby certify that I am eligible
Name of Patient / Member / Guardian

for _____ effective _____.
Health Plan Date

I have chosen _____
Medical Group and/or Primary Care Physician

to be my Medical Provider.

I understand that if the above is not true or if I am not eligible under the terms of my Health Plan Agreement, I am liable for all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from the above noted provider.

_____
Signature of Member/Guardian

_____
Subscriber Number/Social Security Number

PATIENT FINANCIAL RESPONSIBILITY

Orthopedic Medical Group is committed to providing our patients with the highest quality healthcare. We encourage you to contact your insurance company to fully understand your responsibility for any deductibles, co-insurance, or co-payments.

Patient Financial Responsibilities:

The patient (or patient's legal guardian, if a minor) is financially responsible for treatment and care not covered/payable by your insurance plan.

The patient (or patient's legal guardian, if a minor) will be responsible in notifying us of all changes to your insurance coverage prior to your scheduled treatment/care. A copy of your current insurance card must be within our records at all times. You will be asked to present your insurance card at each time of service.

If your insurance requires an authorization for treatment and/or prior authorization for surgery, our staff will make every effort in obtaining the authorization needed for your treatment/care. If we are not properly notified of any changes to your insurance coverage, your treatment may be postponed until we receive authorization. If you choose to proceed with treatment/care without authorization, you will be responsible for full payment of service.

Patients are responsible for deductibles, co-insurance, co-payments and all other procedures or treatments not covered by their insurance plan. Any questions you may have related to these fees should be addressed with your insurance company directly.

Deductibles, co-insurance, and non-covered services are due 30 days from receipt of billing statement.

Co-payments are due at the time of service.

Patients may incur a service charge of $25.00 for all returned checks.

I, _____ have read and thoroughly acknowledge my financial responsibility to Orthopedic Medical Group for any services rendered not covered/payable by my insurance.

Signature of Patient or Legal Guardian **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Orthopedic Medical Group of San Diego, Inc. and all Affiliated Physicians

3750 Convoy Street, Suite 201

San Diego, CA 92111

Privacy Officer: Office Manager (858) 278-8300

I hereby acknowledge that I received a copy of Orthopedic Medical Group of San Diego, Inc. and all Affiliated Physicians 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.

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: _____