Sockolov & Sockolov
Patient Registration Form

Today's Date:	PCP:

PATIENT INFORMATION

Patients Last Name: **First:** **M:**	☐ MR ☐ Miss ☐ MRS ☐ Ms. Language:	Marital Status (circle one) Single/ Mar/Div/Wid

Any Nicknames ☐ Yes ☐ No	If yes please indicate:	Maiden name:	Birth Date:	Age:	Sex: ☐M ☐F

Race: ☐ Caucasian ☐ Asian or Pacific Islander ☐ Black or African American ☐ Hispanic ☐ American Indian or Alaskan Native ☐ Other/Unknown	Ethnicity: ☐ Hispanic /Latino ☐ Not Hispanic /Latino

Street Address:	Social Security Number:	Home Phone Number: ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone Number: ( )

Cell Phone Number: ( )	Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:	Birth Date:	Address (if different):	Home Phone Number: ( )

Is this person a patient here? ☐ Yes ☐ No

Employer Name and Address:	Employer Phone Number: ( )

Please provide insurance(s)	1.	2.

Subscriber's Name:	Subscriber's S.S. #:	Birth Date:	Group #:	Policy #:	Co-payments: $

Patient's Relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other :

Name of Secondary Insurance (If Applicable):	Subscriber's Name:	Group #:	Policy #:

Patient's Relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other :

EMERGENCY CONTACT

Name of Local Friend or Relative (Not living at same address):	Relationship to Patient:	Home Phone Number: ( )	Cell Phone Number: ( )

CAREGIVER/SUPPORT

Name:	Relationship/ Support Role	Home Phone: ( )	Work Phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially resposible for any balance. I also authorize Sockolov & Sockolov or insurance company to release any information required to process my claims.

Patient/Guardian Signature

Parent Signature CONSENT TO TREAT (IF PATIENT IS A MINOR)

Name:
Date of Birth:

Sockolov & Sockolov
Health Information Update

Please provide the following up to date information. If you have already provided this information on Patient Portal, you may disregard this form. If you would like to sign up for Patient Portal, please ask a staff member for information.

1. Please list all of your prior and current medical problems. For example: Diabetes, heart disease, ect.

_____

_____

_____

MEDICATIONS/VITAMINS or HERBAL

Name of Medication	Dose	# times taken daily	Reason taken/ Condition	State date	Stop date

SURGERIES

Surgery	Type	Doctor	Date

ALLERGIES

Allergen	Type of Reaction	Date first noted

Name: **Date:**
Date of Birth

Please indicate the year of your last colonoscopy and where (Doctor):

_____

Please indicate the year of your last mammogram and where (Doctor):

_____

Please indicate the year of your last pap smear and where (Doctor): (if applicable)

_____

Please indicate the year of your last tetanus shot:

_____

Do you have pain which has lasted longer than 3 months in duration? If yes where is the pain located? Are you currently taking any medication for this pain?

_____

_____

_____

Have you heard about advanced directives or POLST? If yes do you have an advanced directive?

_____

_____

_____

<u>Women Only</u>

Menstrual history and birth control method

Are you of child bearing potential? ☐ Yes ☐ No

Current form of birth control _____

☐ Post Menopausal Date _____ ☐ Hysterectomy Date _____

☐ Tubal Ligation Date _____ Performed by: _____

Sockolov & Sockolov
Appointment Policies

In our commitment to provide an exceptional experience for all of our patients, we have adopter the following policies:

LATE TO APPOINTMENT POLICY

We value your time and strive to see you as close to your appointment time as possible. Recognizing unanticipated things happen, we will hold you appointment for a 10 minute grace period after the scheduled start time of your appointment. In consideration of every patient, all appointments will be automatically cancelled after the grace period.

If you arrive after you appointment has been cancelled, you will be asked to reschedule the appointment. If you are willing to wait and the provider can accommodate it, we will try to provide you with a partial or full appointment. Priority is given to our scheduled patients, which means you may have a lengthy wait. If this is not convenient for you, you may choose to reschedule.

New Patients

When scheduling, you will be asked to arrive early for you appointment in order to complete new patient registration forms. If you arrive at your scheduled appointment time and it takes more than 10 minutes to complete this process, you may be asked to reschedule. You may also pick up these forms prior to appointment date or get them online @ www.sockolov.com .

MISSED APPOINTMENT OR "NO-SHOW" POLICY

It is your responsibility to remember your scheduled appointment. After three (3) missed appointments, we may choose to discontinue your care.

Please sign below in acknowledgment of these policies.

_____ _____

Patient/Guardian Signature Date

Sockolov & Sockolov
Patient Consent Form

Patient consent for use and disclosure of Protected Health Information.

I hereby give my consent for Sockolov & Sockolov to use and disclose protected health information (PHI) about me to carry our treatment, payment and health care operations. (The Notice of Privacy Practices provided by Sockolov & Sockolov describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sockolov & Sockolov reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Sockolov & Sockolov 1 Scripps Drive Suite 202 Sacramento, CA 95825.

With this consent Sockolov & Sockolov may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care including laboratory test results, among others.

With this consent, Sockolov & Sockolov may mail to my home or other alternative location any times that assist the practice in carrying out health care operations, such as appointment reminder cards, patient statements as long as they are marked "Personal and Confidential".

With this consent, Sockolov & Sockolov may e-mail to my home or alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements. I have the right to request that Sockolov & Sockolov restrict hoe it uses or discloses my PHI to carry out the health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form I am consenting to all Sockolov & Sockolov to use and disclose my PHI to carry out health care operations. I also understand that any requests to restrict disclosures to my PHI will be a written request.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sockolov & Sockolov may decline to provide treatment to me.

_____ _____

Signature of Patient or Guardian *Date*

_____ _____

Print Patients name *Print Guardians name, if applicable*

Patient/Guardian may request a signed copy of this authorization form

Acknowledgement of Receipt of Notice

Sockolov and Sockolov APC
1 Scripps Dr Suite 202
Sacramento, CA 95825

Diane Borges (916)927-1114

I hereby acknowledge that I am aware of this medical practice's Notice of Privacy Practices.

I would like to receive a copy of any amended Notice of Privacy Practices.

Yes No (circle one)

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the 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*:**

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

Sockolov & Sockolov Patient Financial Policy

Initials	Policy
	Financial responsibility: By these initials and your signature below, you accept financial responsibility for all charges for service rendered to you. If a minor or under a guardianship, the parent or guardian of the patient assumes this liability.
	Proof of insurance: We must obtain a copy of your insurance card in order to bill your claim. We will not take this information over the phone. Patients that have a HMO plan must have one of our doctors as the assigned PCP. If you fail to provide this information in a timely manner (30 days from the date of service), you may be responsible for the bill. If your insurance changes, please notify us before you are seen so we can make the appropriate changes to help you receive your maximum benefits.
	Insurance and non covered services: We participate in most insurance plans, including Medicare. If you are not insured by a plan that we do business with, payment in full is expected at each visit. Please be aware that some, if not all, of your services may be a non covered benefit or not considered reasonable or necessary and will be your financial responsibility. Knowing your insurance benefits is your responsibility. **We will not bill motor vehicle accident insurance.**
	Co-payments and Missed appointments: All co-pays are due at the time of service. This arrangement is a part of your contract with your insurance. If the co-pay is not paid at the time of service, there will be a $10.00 fee assessed. We also charge a fee for appointments not cancelled with in 24 hours of the scheduled appointment, $25.00-per office visit and $50.00 for a scheduled Physical Exam. If you fail appointments more than 5 times, we have the right to discharge you from our practice.
	Slow insurance response: You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your services your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
	Workers Compensation: Our office is more than happy to treat your medical conditions that are related to work comp injuries. However, the proper forms provided by our office for the condition must be completed and signed with in 30 days of the date of service. If your insurance company does not approve the claim, you are financially responsible for the office visit(s). We do not accept third party liens and will not bill your medical insurance for visits related to these injuries.
	Collections and Bank Fees: Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees and collect interest. You agree to be liable for all collection expenses. If you are turned over to a collection agency, you must deal with the agency directly unless you make the payment in full (balance plus fees and interest) to us. In addition, there will be a $25.00 fee for any checks that do not clear or cannot be cashed. Payment on a returned check must be paid in full (amount of check plus $25.00 fee) with cash or a Visa/Mastercard only. After we receive 2 returned checks from the same individual, we will not accept checks as a form of payment.
	Medical Records: The Medical Chart is the property of the practice. However, copies of your pertinent medical information are available upon request. Our office does charge a $30.00 fee for this.
	Patient Discharge: The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. If you are discharged from our practice, a letter will be mailed to you and you must find a doctor within 30 days. We will see you for emergency basis only during these 30 days.

I have read and understand all the terms of this policy and by my signature below, I attest that I fully understand each item and agree to the terms above.

Signature_____ Date_____

Printed Name_____ DOB:_____