CENTRAL COAST GASTROENTEROLOGY MEDICAL GROUP
J. CARLOS HERNANDEZ, MD

PATIENT:
Full Legal Name:____ Male___________Female___________Age____________

Mailing Address:____ Date of Birth______________________________________

City_____________________________________Zip_______________ Home Phone#(_____)______________________________

E-mail____ Cell Phone# (_____)_______________________________

Social Security #(optional)___________________________________ Marital Status: S_____ M_____ D_____ W____DP_____

Primary Care Physician_____________________________________ Employer____

Emergency Contact Person & Phone #___________________________ Address____

____ City ____

____ Phone# (_____) ___________________________________

Preferred method of communication ___Home phone ___Cell Phone Occupation:_______________________________________

PARENT/SPOUSE:
Name:____ Date of Birth______________________________________

Employer____ Phone # (_____) ____________________________________

Address____ Social Security #____________________________________

Local Pharmacy:____
(Any medications prescribed in this office will be available here for your pick up)

Language/Race/Ethnicity Demographic Questions

In order to satisfy the new government requirement for Meaningful Use of Electronic Health Records, we need to ask you about you ethnic origin, race and language preference. Please understand you are under no obligation to answer and you may decline to do so.

Race:
__White
__American Indian or Alaska native
__ Asian
__ Black or African American
__ Native Hawaiian or Pacific Islander
__ Other___________________________
__ Declined to answer

Ethnic Origin:
__ Hispanic or Latino
__ Not Hispanic or Latino
__ Declined to answer

Language:
__ English
__ Arabic
__ Cantonese
__ Hebrew
__ Japanese
__ Korean
__ Mandarin
__ Russian
__ Spanish
__ Other_________________________

****It is your responsibility to know benefits provided by your insurance company****

FINANCIAL POLICY:

- **Medicare:** This office accepts Medicare assignment. This means Medicare pays 80% of the allowable charges and you pay the remaining 20%. In addition, you are responsible for paying the annual Medicare deductible. Supplemental or secondary plans may cover the 20% Medicare allows but does not pay. This office will bill most of these insurance plans. However, you are responsible for any balance of the 20% your secondary does not cover. If the possibility exists that Medicare will not cover anticipated charges, you will be notified in advance and will be asked to sign an Advance Beneficiary Notice (ABN).
- **PPO, HMO (Contracted Plans):** Know your coverage. **All** appointments will be scheduled **after** receiving any required authorization from your insurance company. **Co-pay's are due at the time of service.** We will submit your claim to your insurance carrier. You will continue to receive statements that reflect any insurance payments received by us and any co-payments or balance that you owe.
- **Other Private Insurance (Non-contracted Plans):** If you are covered by an insurance company that our office does not contract with, payment for an office visit is expected at the time of the visit. Payment for hospital services is expected when you receive our statement. While every effort will be made to assist you with the insurance billing, **you**, not your insurance company, are responsible for paying our bill.

AGREEMENT: I have read the financial policy and understand my financial obligations. I hereby authorize Central Coast Gastroenterology Medical Group to release my medical records or other information to the insurance carries, to the physician from whom I was referred, or to any physician or facility to which CCGMG may refer me. I also understand that I am financially responsible for all charges whether or not covered by insurance.

____ __________________________
Signature Date