Patient Registration

Welcome to Seaside!

Patient:	**Date:**	
Street Address/PO Box:		
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email:	D.O.B.	SSN:
Gender: M( ) F( )	Employment: F/T( ) P/T( ) Unemployed( ) Retired( ) Student( )	
Marital Status: Single( ) Married( ) Domestic Partner( ) Divorce( ) Widowed( )		
Emergency Contact Name:	Emergency Contact Phone:	
Emergency Contact Email:	Emergency Contact Relationship:	
Primary Medical Provider:		

Whom may we thank for referring you to us? _____

I certify that the above information is true and correct to the best of my knowledge. I will notify Seaside of any changes made in my status in regards to the above information.

PATIENT SIGNATURE (or Responsible Party) _____

DATE: _____

Clinic Policies

PATIENT PRIVACY: Seaside Medical Practice (Seaside) is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During treatment, it may be required to share information with other medical providers. We follow all Federal and State laws and regulations regarding PHI and information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law. If you have any questions, please contact one of our staff members.

ASSIGNMENT OF BENEFITS: I hereby instruct and direct my insurance company to pay Seaside for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as a payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to Seaside, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment in accordance with my current policy guidelines. _____ (Initial)

24-HOUR CANCELLATION NOTICE: Our healthcare can best be described as low volume and high quality. Each and every appointment has been specifically reserved for you. We ask that you call a day in advance to reschedule or cancel your appointment. A $50 late cancellation fee may be charged to your account if you do not notify us within 24 hours. This fee is not covered by your insurance and will be billed to you directly. After missing two appointments without notice, you will be placed on a same day scheduling policy for your treatments if available. If you continue to miss your scheduled visits, you will be discharged from care. _____ (Initial)

MEDICATION DATA PLAN APPROVAL: In an effort to maximize the quality of your visit with your medical provider, we have implemented a medication data plan which gathers information on your recent prescriptions from local pharmacies. The valuable information is solely utilized by your doctor to systematize a safe and accurate medication plan for you. _____ (Initial)

AUTHORIZATION FOR RELEASE OF INFORMATION: I HEREBY AUTHORIZE Seaside to release my health care information including but limited to testing, diagnosis, and/or treatment plan if any are requested by another treating physician, my insurance company, adjuster, worker's compensation carrier, attorney, my employer (if this is a work related injury), my spouse (if applicable), parents, and adult children. _____ (Initial)

I HEREBY AUTHORIZE any healthcare provider to release my personal health information as it pertains to my care if any is requested by Seaside.

I have read, understand, and agree to the above information, including the 24-hour cancellation policy.

DATE: _____ NAME: _____

SIGNATURE: _____

Payment Policy

In an effort to simplify your billing experience, effective December 1st, 2016, Seaside Medical Practice will process billing statements for services rendered by our office with ***option*** to include your credit card pre-authorization for any outstanding balance. The card on file may be conveniently used for MySeaside membership fees, supplement or skincare orders and any balance due to us after your insurance has processed and paid their portion of your claims. This includes any deductibles, co-pays or non-covered charges. The revised policy will not affect our contract with your insurance carrier. We will continue to bill your Insurance carrier for services rendered and collect co-pays at the time of visit.

I authorize Seaside Medical Practice (Nasimeh Yazdani MD PC) to keep my signature on file and to charge my credit card after a verbal or written authorization at time of transaction by me, for any portion of claim balances that I am responsible for and not paid by my insurance carrier, or any other fees pertaining to membership fees or orders.

Client Name: _____

Cardholder Name (if different): _____

Visa_____ MasterCard_____ American Express_____ Discover_____

Card Number: _____

Expiration Date: _____

CCV (the last three digits on the back of your card): _____

Address associated with card: _____

_____

Cardholder Signature _____

Date: _____

Charge card information is securely filed along with your confidential information.

Financial Policy

Please carefully read through the following financial information and clinic policies. It is important that you have a knowledgeable understanding of your benefits and responsibilities. If you have any questions in regards to the following information please do not hesitate to ask any of the staff members.

MEDICAL INSURANCE COVERAGE: Our providers participate in a select group of regional health plan networks allowing you the benefit of in-network coverage. After collecting a copy of your insurance card, we make every attempt to verify your current insurance coverage. Please understand that it is ultimately your responsibility to know your coverage.
Information that we collect includes: effective dates, deductibles, co-payments and co-insurance amounts. We will review this information with you at your next visit.

Deductible and Co-payments are part of you contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. Co-payments will be collected each visit. If your insurance company reimburses more than the billed amounts we will reimburse you immediately upon overpayment.
Verification of benefits is NOT a guarantee of payment. Please remember that any changes made to your insurance policy may affect coverage and reimbursement rates.

WORKER'S COMPENSATION AND MOTOR VEHICLE ACCIDENTS: It is your responsibility to provide us with the name and address of the insurance carrier along with your claim number. If we do not have verifiable billing information within three clinic visits, your treatment will continue on a cash basis until we receive the necessary billing information pertaining to your injury or obtain private insurance information. If, for any reason, your claim is denied, we will attempt to bill your private health care insurance, but please understand that ultimately you are responsible for full payment.
We do not accept attorney "letter of protection" for claims being disputed or in litigation. If that is the case we will need alternate insurance information or transfer your account to a cash pay basis.

For those patients with worker's compensation claims, we will need to insure that the claim is not part of a managed care organization. If you have information on your enrollment with a managed care organization, please notify us immediately.

MEDICARE: Our providers are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance company provided. You are financially responsible for any co-insurance or your annual deductible if applicable.

NO INSURANCE/CASH RATE: Seaside believes that no one should be denied services secondary to lack of insurance coverage. Our clinic offers a cash rate to those who do not have appropriate insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate.

I have read and understand the financial policy and agree that regardless of my insurance coverage, I am ultimately responsible for full payment of my account with Seaside Medical Practice.

DATE:_____ NAME: _____

SIGNATURE: _____