DIABLO FAMILY PHYSICIANS

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NAME OF PATIENT: _____ D.O.B. _____

Acknowledgement of Receipt of Notice of Privacy Practices and Shared Electronic Medical Record: Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff and certain members of the participating physicians of John Muir Health and their staff's access to our patients' health information. The purpose for this access is to expedite the referral of patients within the John Muir Health system and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the John Muir Health system only with the patient's expressed authorization or as otherwise specifically permitted or required by law. I hereby acknowledge that I am aware that a copy of this medical practice's Notice of Privacy Practices is available to me in the office and copy of any amended Notice of Privacy Practices will be available at each appointment. We encourage you to read it in full. I also authorize Diablo Family Physicians, Inc. to release all medical information necessary to any hospital, specialist, lab or insurance company acting on my behalf concerning: advice, care, treatment, any services including drug, alcohol or mental health treatment information for purposes related to the administration of billing and claims.

Initial Here _____

Assignment of Benefits/Financial Policy: I hereby assign medical and/or surgical payments to include any medical benefits to which I am entitled to Diablo Family Physicians, Inc., for services provided by the stated medical group. I understand if claims are denied due to eligibility status, an invalid medical group, invalid Primary Care Physician or any other reason, I will assume full responsibility for all charges incurred by myself and my dependants. Additionally, I will be financially responsible for any non-covered benefits, deductibles and co-payments at the time of service. I am fully aware of the penalties of late payment of invoices/bills. For every additional invoice/bill sent after the initial invoice/bill I could be charged a $15.00 rebilling fee, unless invoice is currently being discussed due to dispute in payment amount. This will be noted on your invoice/bill. There is a $25.00 returned check fee. If you do not have your co-pay at the time of service there could be a $15.00 invoice/billing fee. **It is my responsibility to understand my insurance benefits and coverage plan.**

Initial Here _____

Cancellations/No Shows/Telephone Calls: Please call no later than 24 hours prior to the appointment to reschedule/cancel your appointment or this will be considered a no show. **The charge for a no show will be $50.00 for a routine office visit and $100.00 for a physical**. We reserve the right to bill for telephone calls for routine questions up to $10.00/call; we will notify you of the charge at the time of the call.

Initial Here _____

Form Completion/Photocopying: There will be a charge of $ 15.00 if you require a duplicate for a sports physical or single page school form. Forms greater than one page that are not received and completed at the time of visit (DMV, Disability, FMLA, etc…) will be $25.00. Copies of your medical record will be a minimum charge of $15.00 and then 25 cents per page. Letters written by the provider will start at a minimum of $25.00.

Initial Here _____

Limitation of our Responsibility: I understand that Diablo Family Physicians, Inc. makes no promises and is not responsible in any way financially for any non-covered benefits and does not guarantee or takes responsibility for in or out of network status related to your health plan. This includes but is not limited to any labs, tests, procedures, referrals, consultations or any other medically related services that are recommended, ordered or submitted by this or any medical office. **We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage. We typically submit our office specimens to Lab Corp Laboratories unless specifically requested at the time of service of every visit.** Initial Here _____

Parental Consent for Treatment of Minor Without Parent Present: I hereby allow for the below minor child to receive medical treatment at Diablo Family Physicians, Inc. without my presence. If circumstances permit and state and federal privacy laws allow, I would like to have the provider consult in connection with such treatment. Please attempt to contact me at the below telephone number. This authorization shall be effective until the minor's 18th birth date.

The above policies will remain in effect until revoked by me in writing. A photocopy or scanned image of this document is considered as valid as the original. Any newer copy supersedes any previously completed notification forms.

Signed: **Patient or Guardian**: _____ Date: _____

If not signed by the patient, please indicate relationship: _____

☐ Parent or guardian of minor patient Telephone: _____

☐ Guardian or conservator of an incompetent patient

FOR OFFICE USE ONLY:

Reason for Inability/Refusal to obtain Signature: _____

Diablo Family Physicians Staff Signature/Name: _____ Date: _____