Registration Sheet

9834 Genesee Ave, Suite 228 La Jolla, CA 92037 • 955 Lane Ave, Suite 200 Chula Vista, CA 91914
1763 West 24th Street, Suite 105, Yuma AZ 85364

PATIENT INFORMATION

Name: _____ _____ _____ _____/ _____/ _____ _____ Gender: M/ F
Last First M Date of Birth Age

Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Address: _____ City: _____ Zip: _____

Phone: Home ( ) _____Cell ( ) _____

Social Security Number: _____-_____-_____ Email: _____

Primary/Referring Physician: _____

Current Employer: _____ Occupation: _____ Phone: ( ) _____

Work Address: _____

Pharmacy: _____ Phone: ( ) _____

SPOUSE/PARENT OR EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: ( ) _____

INSURANCE INFORMATION

_____ _____ _____
Insurance Company Policy Number Group Number

Name of insured (If not patient): _____ Date of Birth (If not patient): _____/ _____/ _____

Address (if not same as patient): _____

SECONDARY INSURANCE INFORMATION

_____ _____ _____
Insurance Company Policy Number Group Number

Name of insured (If not patient) _____ Date of Birth (If not patient): _____/ _____/ _____

I hereby certify that the above information is correct and accurate to the best of my knowledge. I understand that Synergy Specialist Medical Group will assist me in obtaining benefit verification and authorizations as required; I also understand that this does not guarantee payment from my insurance company. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to , deductibles, co-pays, co-insurances, ans services not covered under my plan. . I also authorize Synergy Specialist Medical Group to submit claims on my behalf and obtain any and all records they determine necessary for my treatment and to obtain payment. In the event that Synergy Specialist Medical Group is unable to collect any portion of my bill from my Insurance company, I will be personally responsible for any and all charges and balances allowed by law. I also assign to Synergy Specialist Medical Group any and all insurance benefits and ask that payment for services rendered to me will be made payable and directed to Synergy Specialist Medical Group.

* Authorization to release information: I hereby authorize the release of any medical or other information to my insurance company to process claims for services rendered.
* HIPPA Policy: I hereby acknowledge that I have been offered the Notice of Privacy Practice of Synergy Medical Group.
* Notice to Consumers: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

_____ _____ _____/ _____/ _____
Patient Signature Print Name Todays date

John H. Serocki, M.D.

Patient Name: _____ Today's Date _____

Age: _____ Height: _____ Weight: _____ Dominant Hand: Right Left

Occupation: _____ Employer: _____

What symptoms are you experiencing (What Hurts)?

_____

_____

How did you get injured or what caused these symptoms?

_____

_____

Have you had any treatment for these symptoms?

(If yes, please list name of facility or physician)

_____

_____

Have you had any recent imaging done? □ Yes □ No

□ X-Ray □ MRI □ Ultrasound □ CT scan □ other

Where? _____ When? _____

Do you have any allergies to Medication/Substance? □ Yes □ No □ I Don't Know

(If yes, please list)

Medication/Substance: _____ Reaction: _____

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Are you taking Medication? □ Yes □ No

Medication: _____ Dose: _____ Used for: _____ How Often _____

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Medication: _____ Dose: _____ Used for: _____ How Often _____

List any surgeries or hospitalizations, including date(s) done.

Surgery _____ Date _____ Work Related? Y N

Surgery _____ Date _____ Work Related? Y N

Surgery _____ Date _____ Work Related? Y N

Have you used any of the following substances: Circle No or Yes and fill in the blanks.

SUBSTANCE	CURRENTLY USE	PREVIUOSLY USED	HOW OFTEN	HOW LONG	IF STOPPED, WHEN
Caffeine: coffee, tea, soda	**NO YES**	**NO YES**			
Tobacco	**NO YES**	**NO YES**			
Alcohol: beer, wine	**NO YES**	**NO YES**			
Recreation/Street Drugs	**NO YES**	**NO YES**			

Circle any medical condition(s) that you currently have or have had previously:

Heart Attack	**Stroke**	**Cardiac Stent**	**Cardiac Condition**	**Heart Disease**
High Blood Pressure	**Diabetes**	**High Cholesterol**	**Thyroid Disease**	**Thyroid Disease**
Liver Disease	**Gastritis or Ulcers**	**Polio**	**Tuberculosis**	**Thyroid Condition**
Fibromyalgia	**Hepatitis A, B, C**	**Rheumatoid Arthritis**	**Gout**	**Blood Clots**
Anemia	**Osteoarthritis**	**Emphysema**	**Epilepsy**	**Enlarged Prostate**
Asthma	**Sleep Apnea**	**Neurological Disease**	**Recurrent Headaches**	**Recent Weight Loss**
Constant Night Pain	**Fever or Chills**	**Depression**	**HIV/AIDS**	**Drug Abuse**

Please list any medical condition not listed above:

_____

_____

Family Medical History:

Please list any medical condition(s) that run in your family medical history:

_____

_____

_____

Please list any leisure activities, including sports or athletic, that you participate in:

_____

_____

_____

****

Medical use only

John H. Serocki, M.D.

Payment and Insurance Billing Policy

Thank you for allowing our practice to be your provider of choice. We are committed to providing you with the highest quality affordable health care. Some of our patients have had questions and confusion regarding their insurance and individual responsibility for the services we provide. This is why we have developed this policy to provide some basic information you may need to make the financial decisions that may arise during the course of your care. Please read it and feel free to ask any questions you may have. We ask you to also sign below to acknowledge your understanding and acceptance. A Copy will be provided to you upon your request.

1. **PAYMENT FOR SERVICES IS DUE AT THE TIME SERVICES ARE RENDERED.** We accept Cash, Checks and Visa/Medicare.

2. **HMO AND COVERED CALIFORNIA:** Our practice does not participate with any HMO or Covered California insurances.

3. **INSURANCE:** We participate with most PPO's and PPO options within POS plans as well as Fee for Service insurance plans and Medicare. If you are insured with a plan we do not participate with, payment in full will be expected for each visit, at the time services are rendered. If you are insured by a plan we do participate with, you must have a valid member ID card and corresponding picture ID that we can verify. If you are unable to produce these items or we are unable to verify active coverage, you may be required to guarantee full payment for services rendered until such time as your coverage can be verified. Knowing your insurance benefits is your responsibility, if you are unsure about your benefit or participation with your plan; please give them a call at the number on the back of your card.

4. **CO-PAYMENTS AND DEDUCTIBLES:** It is a requirement of your insurance plan member/subscriber agreement as well as our practice policy that all co-payments and deductibles must be verified and paid at the time of each visit. Failure to pay or collect these monies could lead to a delay in payment of your benefits by your insurance company as well as an additional administrative charge of $25 to you. A $50 fee will be assessed for each check or electronic transaction denied by your bank for any reason.

5. **ARBITRATION AGREEMENT:** You will be asked to sign an arbitration agreement prior to being seen in our practice. By signing this agreement we are agreeing that any dispute arising from the medical services you receive is to be resolved through binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that resolving disputes by arbitration is the most equitable means for all parties involved. We are agreeing to modify the forum for presenting claims. Each party will select an arbitrator, who then agrees to select a third, neutral arbitrator. The issue is presenting to all three arbitrators who agree to a solution. This arrangement helps to limit the legal cost, inconvenience and rigors of formal judicial proceeding for both parties. Our goal is to provide medical care in such a way to avoid any such dispute. We understand that most problems begin with communication. Therefore, if you have any questions about your care please ask to speak with our office manager.

6. **NON-COVERED SERVICES:** Please be aware that some and perhaps all of the items or services you receive may be non-covered or not considered to be reasonable or necessary by Medicare or other insurance companies. It is your responsibility to contact your insurance company if you have concerns. It is also your responsibility to pay for non-reimbursed items or services in full at the time of your visit.

7. **PROOF of INSURANCE:** All parties must complete our patient information form as well as any other required forms prior to being seen by a provider. We must also obtain a copy of your current insurance ID card and a valid State ID or Driver's License at the time of your visit. We will make a good faith effort to contact your insurance company to verify your coverage and benefits. Please understand that if we are unable to verify this information, you may be required to guarantee payment in full until such time as this information can be verified. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance of the items and services rendered.

8. **CLAIMS SUBMISSION:** Our practice is committed to providing the most effective treatment for our patients and our fees are representative of the usual and customary charges for our area. If we are a provider with your plan, it is our policy to submit your claim to your insurance company and assist you in attaining the co-insurance or shared portion of your claim to your insurance company to calculate the proper amount due from you, the subscriber. It is sometimes necessary for your insurance company or our billing office to contact you directly for information or assistance. It is your responsibility to comply with this request in a timely manner. Please understand that the balance of your account is your responsibility whether your insurance company pays your claim or not. It is all parties' best interest to cooperate in this matter. We ask you to review all correspondence carefully and contact your insurance company or us immediately with questions or concerns. If we do not receive appropriate payment from your insurance company within 45 days from the date of submission, the entire balance may become your responsibility. Your insurance benefits are a contract between you and your insurance company; we may not be party to the contract.

9. **COVERAGE CHANGES:** If your insurance changes, it is YOUR responsibility to notify us before your next visit so we can make the appropriate changes to assist you in receiving your maximum benefits. If you do not notify us prior to your next visit, we may be unable to properly bill for your services and full payment will be your responsibility.

10. **NONPAYMENT:** As a courtesy, we will provide you with statement of your account. It is your responsibility to review these statements for accuracy and respond immediately to any and all request for information and payment. We are required by federal law to report any and all services rendered supported by the actual documentation contained in your medical record. We cannot under any circumstance alter a claim to obtain payment. If you discover an error, duplicate charge or have any concerns about your bill, please contact our office immediately for investigation and proper corrective action. All outstanding balances are due upon receipts and past due 30 days later. Any account 90 days past due is subject to collection action to the full extent of the law. Partial payments will not be accepted without a written agreement and may be returned as unacceptable. Please understand that in the event that your account is referred for collection you will be responsible for any additional charges and cost attributable to that action, including but not limited to agency, attorney and court cost incurred and permitted by the laws governing these actions. Also be aware that you may be discharged from the practice for non-compliance and no further treatment will be forthcoming. If this is to occur, you will be notified by certified mail at your last known address. This letter will allow you 15 days to find alternative medical care. During that 15 days period, your physician will only be able to treat you on an emergency basis and at the conclusion of that period you will no longer be seen in our practice. It is your responsibility to provide us with the name and contact information for your new provider and we will forward any appropriate records/information to them at that time.

11. **MISSING APPOINTMENTS**: It is the policy of our practice to charge a $50.00 fee for a missed appointment. A missed appointment is any appointment not cancelled at least 1 business day prior to the schedule time. It is your responsibility to contact our office by phone; a voice mail message is not adequate. These charges will be billed directly to you and are due prior to your next scheduled appointment. We understand that scheduling conflicts happen, please help us to serve you better by keeping your appointment.

12. **EXTRA FEE:** There will be a charge of $20.00 for copying of your records including a copy of x-rays. There is a charge of $20.00 for completion of forms.

Thank you for taking the time to review our financial policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the guidelines outlined in this policy.

_____----------	_____----------
Patient Name	Social Security #
_____----------	_____----------
Patient Signature	Date
_____----------	_____----------
Witness	Date

John H. Serocki, M.D.

Confidential Channel Communication Request

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment. **This request supersedes any prior request for confidential channel communications I may have made.**

☐ **I give Permission for my physician/staff to speak with the following family member or significant other regarding confidential health information, only when medically necessary, or in my best interest:**

Name: _____

Name: _____

☐ **Phone**

I want you to contact me by telephone at _____

☐ Do ☐ Do not leave messages on my answering machine.

☐ Do ☐ Do not leave messages with any other person.

☐ **Mail**

I want you to contact me at the following address _____

_____

☐ **E-mail**

I want you to contact me at the following e-mail address: _____

☐ **Fax**

I want you to contact me at the following fax number: _____

☐ **Other** _____

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate:

Relationship:
- ☐ Parent or guardian of minor patient
- ☐ Guardian of conservator of an incompetent patient
- ☐ Beneficiary of personal representative of deceased patient

Name of patient: _____

****

For office use only:

Date Granted: _____

Date Terminated of Modified: _____