San Dimas Family Clinic

150 W. Foothill Blvd, San Dimas CA 91773
PH:909-599-9921 FX: 909-592-3147

REGISTRATION FORM

(PLEASE PRINT)

Today's date:	PCP: **CLIFFORD L. SUSSMAN, M.D.**

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F

Primary Language:	SSN:	Driver's License #:
EMAIL:	RACE:	ETHNICITY:
Street address:	P.O. BOX.:	City:

State:	ZIP CODE:	Home Phone: ( )	Cell Phone: ( )
Occupation:	Employer:		Employer phone #: ( )

Advance directive: do you have an advance healthcare directive? _____Yes _____No (if yes, please give the office a copy)
Would you like information about Advance healthcare Directives? _____yes _____No

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Work /Cell phone #: ( )

x_____ ***INITIAL—CONSENT TO TREAT:*** I HEREBY REQUEST AND AUTHORIZE SAN DIMAS FAMILY CLINIC TO PROVIDE SUCH MEDICAL/SURGICAL CARE, TESTS, PROCEDURES, MEDICATIONS, AND OTHER SERVICES AND SUPPLIES AS ARE CONSIDERED NECESSARY OR BENEFICIAL FOR MY HEALTH AND WELL-BEING. IT IS UNDERSTOOD THAT THIS CONSENT IS GIVEN IN ADVANCE OF ANY SPECIFIC SERVICES, BUT IT IS GIVEN IN ORDER THAT SAN DIMAS FAMILY CLINIC MAY EXERCISE THEIR BEST JUDGMENT AS TO PROPER MEDICAL CARE WHICH MAY BE NECESSARY TO PROTECT MY LIFE AND HEALTH.

x_____ ***INITIAL—ASSIGNMENT OF BENEFITS:*** I HEREBY ASSIGN DIRECTLY TO SAN DIMAS FAMILY CLINIC ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE

x_____ ***INITIAL—DISCLOSURE OF PHI:*** I HEREBY AUTHORIZE SAN DIMAS FAMILY CLINIC TO RECEIVE AND OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME FOR THE PURPOSE OF TREATMENT, PAYMENT, AND OPERATIONS. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT OTHER DISCLOSURES WILL BE MADE ONLY WITH MY WRITTEN AUTHORIZATION, UNLESS OTHERWISE PERMITTED OR REQUIRED BY LAW. A COMPLETE "NOTICE OF PRIVACY PRACTICES" FOR SAN DIMAS FAMILY CLINIC HAS BEEN OFFERED TO ME.

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 responsible for any balance. I also authorize San Dimas Family Clinic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

San Dimas Family, Clinic
Clifford L. Sussman, M.D.
150 W. Foothill Blvd., San Dimas, CA 91773

Office Policy

***Billing Insurance Companies:** We will bill most insurance companies as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you. You must provide us with the correct, most recent card. If you do not have a card, we will accept an enrollment form or faxed verification from your insurance carrier. In the event that you cannot provide us with the proper verifiication, you are required to leave us a check. We will hold your check for three working days, in which time you must provide us with the necssary information. If you do not, your check will be processed.

***Co-payments and Deductibles are due when services are rendered:** We do not bill for co-payments. Private insurance patients are responsible for all charges not paid by their insurance company within 45 days after the date of service. Payment arrangements can be made on an individual basis at our discretion. We reserve the right to withdraw the extension of credit.

***Financial Responsibility:** In the event that you are not eligible for service coverage with this provider or are not eligible at the time services are rendered, you will be held financially responsilbe. Cash Patients payments are due at the time of service. We will not bill Cash Patients for services.

***Late Payments**: If you are unable to pay the full amount of your balance within one month of receiving an Explanation of Benefits from your insurance or a statement from our office, you may call to set up a payment plan as stated above. If you fail to make said payments or pay your balance there will be a $10.00 charge each month you are late.

***Failed Appointments**: If you are unable to keep a scheduled appointment, you are required to give *24-hour* advanced notice. In the event that you fail to provide *24-hour* advanced notice to cancel an appointment, or failure to show for an appointment, you will be charged a $25.00 fee.

***Late Appointment**: We strive to stay on schedule and make every effort to see our patients as near to their appointment time as possible. To stay on tract, if you are late 15 minutes or more for your appointment we rechedule your apppointment for another date and time.

I Declare under penalty of perjury under the laws of the Sate of California that I have read the foregoing, that I understand it, and that by excuting this document in the City of San Dimas, California, I accept and agree to its contents.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name Date of Birth