CHRIS THREATT, M.D.
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Redwood City, CA 94063
Phone (650) 465-6038
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PATIENT REGISTRATION FORM

Primary Care Physician:			**Referring Physician:**	
PATIENT INFORMATION				
Patient's Last Name	**First Name**		**Middle Name**	
Street address:		**City:**	**State:**	**Zip Code:**
Home phone:		**Cell phone:**		
Birth date:	**Age:**	**Pharmacy Name:**	**Street/City of your pharmacy:**	
Okay to download medication history? □ Yes □ No		**Email Address:**		
Preferred Language:		**Do you require mobility assistance?** □ Yes □ No		
Do you have an Advance Directive? □ Yes □ No		**If Yes: DNR** □ Yes □ No		
Surrogate Decision Maker: If YES name:				
Do you have power of attorney? □ Yes □ No	**If yes, person's name:**	**Phone Number:**		

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Phone number:**

INSURANCE INFORMATION (Please bring cards with you to appointment)

Name of PRIMARY insurance:	**If insurance is not under your name, list name and DOB**
Name of SECONDARY insurance (if applicable):	**If insurance is not under your name, list name and DOB**

FINANCIAL POLICY

CASH PATIENTS

- Full payment at time of service.
- We accept CASH, VISA, MASTERCARD, and AMERICAN EXPRESS

HMO HEALTH PLANS

- Referral required for initial visit, please have referring physician submit
- Inquire with office prior to appointment to ensure we are in network with your HMO

PRIVATE INSURANCE CARRIERS

- When we are provided with insurance information, we will submit the visit to your insurance company for you.
- On subsequent visits, we will bill your insurance carrier; although we expect any deductibles and co-payment percentages at the time of your visit**.** If your insurance has not paid the full balance or denied the claim, then you are responsible and we expect payment from you within 30 days upon the receipt of our statement.

  Insurance coverage is a contract between you and your insurance company. We are not a party to this contract in most cases. Your insurance claim is filed as a courtesy to our patients. We will not become involved in disputes between you and your insurance carrier regarding deductibles, co-payments, etc., other than to supply factual information as necessary**. You are ultimately responsible for all charges regardless of any existing medical coverage.**

MEDICARE

- If you are covered by Medicare or any other government-sponsored program, we require that you have proof of such coverage for billing purposes.

Should your account become past due, you will be responsible for any finance charge or legal fees necessary to collect on this account.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

CANCELLED APPOINTMENTS

- **This office requires a 24-hour notice if you are unable to keep your scheduled appointment, 48-hour notice for any procedures or surgeries.**
- **A $100 cancellation fee has been implemented in order to reduce the amount of failed OV appointments or appointments cancelled by patients without proper notice. The cancellation fee for procedures or surgeries will be 50% of the procedure charge up to a maximum of $500.00.**

Responsible Party Signature: _____

Print Name: _____ Dated: _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I have received the Chris Threatt, MD, Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any further Notice of Privacy Practices if amended.

I wish to be contacted in the following manner (check all that apply):

Phone: _____

□ O.K. to leave message with detailed information
□ Leave message with call-back number only

Family members authorized to receive medical information: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

- ***AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES***

  I herby authorize Chris Threatt, MD to release any information in the course of my examination and/or treatment to my insurance company(s) for the purpose of billing. I also authorize the release of information to my employer if my examination and/or treatment are work related.

- ***AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN***

  I herby authorize the medical and/or surgical benefit payments to be made directly to Chris Threatt, MD. It is understood that benefits are not to exceed the reasonable and customary charge of these services and any monies received from the insurance company over and above indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges not covered by this authorization.

- ***INFORMED CONSENT FOR OFFICE PROCEDURES***

  I herby authorize the staff and physicians of Chris Threatt, MD to perform those diagnostic and/or therapeutic office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that the above names company will verbally describe the nature of said procedures in lay terminology, including possible complications, alternatives, and side effects and obtain verbal consent prior to procedures. I retain the right to verbally refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications, and side effects.

- ***PATIENT ACKNOWLEDGMENT OF PHYSICIAN DISCLOSURE OF OWNERSHIP % INTEREST***

  This is to advise you that the doctors have ownership interest in certain diagnostic equipment and diagnostic treatment centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred.

  I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPHS.

_____ _____

Print Patient Name **Patient's Birthdate**

_____ _____

Patient Signature or authorized representative **Date**