Patient Information

RESPONSIBLE PARTY'S INFORMATION:

(PERSON WHO CARRIES INSURANCE)
(PLEASE DO NOT PUT PATIENTS INFORMATION IN THIS SECTION)

LAST NAME: _____ FIRST NAME: _____
HOME ADDRESS: _____
CITY: _____ ZIP CODE: _____
HOME TELEPHONE: _____ OKAY TO LEAVE MESSAGE YES/NO
CELL/WORK PHONE: _____ OKAY TO LEAVE MESSAGE YES/NO
EMPLOYER NAME: _____ OCCUPATION: _____
EMPLOYER ADDRESS: _____
DATE OF BIRTH: _____ MALE _____ FEMALE _____
SOCIAL SECURITY # (FOR BILLING PURPOSES): _____
DRIVERS LICENSE # _____
MARITAL STATUS: SINGLE_____ MARRIED_____ OTHER _____

SPOUSE/SECOND PARENT INFORMATION

LAST NAME: _____ FIRST NAME: _____
HOME ADDRESS: _____
CITY: _____ ZIP CODE: _____
HOME TELEPHONE: _____ OKAY TO LEAVE MESSAGE YES/NO
CELL/WORK PHONE: _____ OKAY TO LEAVE MESSAGE YES/NO
EMPLOYER NAME: _____ OCCUPATION: _____
EMPLOYER ADDRESS: _____
DATE OF BIRTH: _____ MALE _____ FEMALE _____
SOCIAL SECURITY #): _____

DEPENDENTS: (NAME OF ALL CHILDREN WHO WILL BE SEEN AS PATIENTS IN OUR OFFICE)

LAST NAME	FIRST NAME	DATE OF BIRTH	M/F
1.			
2.			
3.			
4.			
5.			

CHILD/CHILDREN LIVE WITH: MOTHER _____ FATHER _____ BOTH PARENTS_____
CONTACT PERSON IN CASE OF EMERGENCY (OTHER THAN PARENT) _____
EMERGENCY CONTACTS PHONE # _____
WHO MAY WE THANK FOR YOUR REFERRAL: _____
EMAIL ADDRESS (FOR UPDATES FROM OUR OFFICE) _____

AUTHORIZATION (PLEASE READ BEFORE SIGNING)

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE COMPANY. I AUTHORIZE THE PROVIDER OF SERVICE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I ALSO CONSENT TO THE EXAMINATION AND/OR TREATMENT OF ALL MINOR CHILDREN LISTED ABOVE BY PHYSICIANS, PHYSICIANS ASSISTANTS AND OTHER MEDICAL PERSONNEL. FAILURE TO PROVIDE COMPLETE INFORMATION MAY RESULT IN YOUR RECEIVING A BILL FOR YOUR CHARGES.

Signed _____Date_____ Relationship to Patient _____

ANGELA ALLEVATO MD
431 S. BATAVIA ST. SUITE 203
ORANGE, CA. 92868

Angela Allevato MD
(714) 639-0662

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

□ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

□ parent or guardian of minor patient

□ guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Language Preference Form

Angela Allevato MD

431 S. Batavia St. Ste 203

Orange, Ca 92868

Patient (s) Name: _____

Patient (s) D.O.B: _____

Primary Language: English _____ Spanish _____ Other _____

Language Preference: English _____ Spanish_____ Other _____

Hearing Impaired: Yes_____ No _____

Interpreter Needed: Yes_____ No _____

Angela Allevato MD
431 S. Batavia St. Ste 203
Orange, CA 92868
(714) 639-0662

STATEMENT OF FINANCIAL POLICY

Thank you for choosing the office of Dr. Angela Allevato MD as your health care provider. We are committed to the success of your treatment and care. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy, which we ask all our patients to read and understand. If you have any questions, please feel free to discuss them with our office staff, (714) 639-0662.

We will be happy to bill your insurance company, but we need complete information including a copy of your insurance card. Please give that information to our front desk staff.

Methods of Payment: We accept cash, Checks, Visa and MasterCard.

About your insurance coverage:

- **Commercial Insurance-** Your policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance is your responsibility weather your insurance pays or not. As a courtesy, we will file a claim on your behalf.
- **Managed Care Plan-** (HMO, POS, PPO)- You will need to pay any copayments, and non-covered services at the time services are rendered. A copayment is required per your insurance contract for all services done in the office. This includes (MD visits, Nurse only visits, Shots only, and re check appointments.) It is your responsibility to verify a physician's participation in your health plan prior to making an appointment.
- **Self Pay-** Patients who do not have insurance coverage, who have insurance coverage but are unable to provide us with valid insurance information, or who wish to file their own claims, are responsible for 100% of charges at the time services are rendered.

Missed Appointments:

If an appointment is not canceled or rescheduled within 24-hours of your appointment time it is considered a no show which will result in a $25 fee. More than three no showed appointments in a six month period may result in discharge from this practice.

If you arrive to your appointment more than 15 minutes late you may be asked to reschedule for a later date or time.

Billing and Credit:

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you make every effort to pay your bill promptly. All copayments are due at the time services are rendered in office. A copayment is required per your insurance contract for all services done in office. This includes (MD visits, Nurse only visits, Shots only, and re check appointments.)

Past Due Balances:

If you have not paid your past due balance within 90 days, we will seek the assistance of a collection company. If your account is assigned to a collection agency, you will be discharged from the practice and asked to seek medical care elsewhere. If you have issues that prevent you from paying the full amount that is due, please contact our office so we may help find a solution. **All accounts not paid after 30 days are subject to finance charges.**

School Forms:
Our office will be happy to complete forms at no charge. Please allow 5 business days for completion of the forms. If the form is needed sooner, there may be a charge for this service.

Returned Checks:
The fee for all checks returned for insufficient funds is $25.00. This fee will be automatically charged to your account when your check is returned from the bank.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY AND AGREE TO ITS TERMS.

_____

_____

_____

_____
Print Patients Name (all who are patients)

_____ _____ _____
Signature of Parent or Legal Guardian Please print name Date