Aspen Medical Group, Inc.

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Corona, CA 92879
Fax 951-735-8560
951-735-6969

PATIENT INFORMATION / OB REGISTRATION

LAST NAME:	MIDDLE NAME:	FIRST NAME:
AKA (also known as):	DATE OF BIRTH:	SOCIAL SECURITY #:

STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	WORK PHONE:	
CELL PHONE:	E-MAIL:	

PREFERRED PHONE: ❑ HOME ❑ CELL ❑ WORK

RACE:	ETHNICITY:	LANGUAGE:
MARITAL STATUS:	EMPLOYMENT / OCCUPATION:	RELIGION:

EMERGENCY PHONE:	NAME & RELATIONSHIP:
EMERGENCY PHONE:	NAME & RELATIONSHIP:

An advanced health care directive is a document that specifies what actions should be taken for your health in the event you are no longer able to make decisions due to illness or incapacity. Do you have an advance health care directive?
❑ Yes ❑ No

PRIMARY CARE DOCTOR'S NAME:	**REFERRED BY:**
PRIMARY CARE DOCTOR'S PHONE:	❑ Friend ❑ Insurance ❑ Website ❑ Internet
PHARMACY NAME / STREET / CITY:	❑ Doctor (name): _____
PHARMACY PHONE:	❑ I am an established patient
	❑ Other: _____

PREFERRED HOSPITAL: ❑ Riverside Community Hospital ❑ Parkview Community Hospital ❑ Corona Regional Medical Center

INSURANCE NAME:		
SUBSCRIBER NAME:	SUBSCRIBER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payment directly to *ASPEN MEDICAL GROUP, INC.* of the medical expenses benefit payable to me. I hereby authorize the release of any or all medical information to my insurance company, as may be necessary for the completion of claims for payment. I agree to notify this office immediately if my benefits change. I understand I am financially responsible for any balance or charges not covered by insurance carrier.

Patient Signature_____ Date_____

WELCOME TO OUR OFFICE

The staff at Aspen Medical Group, Inc., is committed to providing you with the best possible care. To achieve our objective easily we need your support and cooperation. YOU, the patient, share a responsibility in reaching this goal. It is your responsibility to know and confirm your insurance benefits prior to coming to our office. Confirm that we are within your plan's network of physicians. Bring your insurance identification card and show it to our front desk staff when asked. Pay your co-payments at the time of service, keep your appointments, and call ahead of time when you cannot keep your appointment. Notify us of any changes in your registration information (did your address or telephone number change?). Most importantly, abide by the follow up care instructions of our professional medical staff. We request that you read and understand our payment policies.

Payment Policy

Payment of co-insurance or co-payment amounts is collected at the time service is rendered. We will bill your insurance of the portion they pay based on your plan benefits. For your convenience we accept cash and all major credit cards. Any requested payment arrangements must be approved by our Financial Department. Co-payments are collected at check-in; if you come unprepared and are unable to pay your insurance co-payment, your appointment will be rescheduled. It is a good idea to arrange your appointment around your payday schedule – please consider this when you call to make your appointment because **we expect you to come prepared to pay your co-pay, unmet deductible amounts, and any remaining balance on the day you receive services.**

Our computer system holds most insurance plan contract rates and we are immediately able to calculate the amount of your co-payment, surgery share of cost, and deductibles. If any required information is missing, our staff is trained to view your insurance benefits online and they also contact the insurance company directly, if necessary. **We collect at the time services are provided.** If, for some reason you overpay, a refund will be processed as soon as the overpayment is entered into our computer system.

After receiving your care, we ask that you watch for your explanation of benefits (EOB) from your insurance plan. Patients usually receive the EOB prior to the medical office receiving the insurance payment. If you have not received one within 45 days of service, please contact them and inquire as to any reasons for the non-payment.

If you are on a signed payment arrangement plan and a problem arises that affects your ability to continue making timely payments, you must contact our Financial Department immediately for assistance in the management of your account. Communication is key; it helps us avoid having to turn over your account to a collection agency. Once in collections, additional interest and fees will accrue and the collection agency does report all balances to TRW. In the event of an account being placed with the collection agency, no further appointments for new problems will be made until the prior debt is resolved.

A fee of $25.00 will be charged to your account for any returned checks. From that point on, we will only accept cash, money orders or credit cards for any payment currently due on your account for future medical services rendered.

Disability Forms
As a courtesy we will complete your state disability form free of charge. However, a fee of $15.00 will be charged for each private disability form. The fee must be paid when the form is brought to our office for completion. Please be sure to read the form instructions and fill out your portion completely. Incomplete forms will be returned to you. The completed form will be mailed directly to the address provided on the form. Please make sure the address is correct. Please provide correct postage stamp on envelope for mailing.

Medical Records Request
If the need arises where you would need medical records, we require a 48-hour notice to process your request. There is a $25.00 copy of records fee, unless requested by a medical facility. Medical record requests must be in writing and on a signed and dated medical release form. Our Medical Records Department will be happy to fill your request once you meet these simple requirements.

Prescription Refills
If you are taking medications prescribed by our providers and you need a refill, please call your pharmacy first. Your pharmacy will fax over the refill request, per established guidelines. We ask that you allow 48 hours for processing your request. Make sure you call in your refill while you still have a few days of medications remaining to get you through the 48 hour period (this refers to business working days Mondays through Fridays).

Appointments
If you are unable to keep your appointment, kindly give us at least 24-hour notice for cancellation. Any appointments not cancelled or missed will incur a charge of $20.00 for a **No Show** fee. Payment is due before any further services can be provided.

For prenatal care, we expect you to follow up with routine appointments as scheduled, unless otherwise discussed with your provider. If more than 60 days pass since your last office visit, you understand that Aspen Medical Group, Inc., will terminate you from our prenatal care services.

If you have any questions regarding our policies, please do not hesitate to ask.
By my signature below, I acknowledge that I have read and understand the office policies stated above and agree to accept the described responsibilities.

_____ _____
Patient or Guarantor Date

_____
Patient (printed name)

_____ _____
Parent or Guardian Date

ASPEN
Medical Group, Inc.

COMMUNICATION CONSENT AGREEMENT

I understand, that under federal law (HIPAA), this medical office may **NOT** release any medical information to any individual without my express written permission. Law Enforcement and Court Order are two exceptions to this requirement. I, therefore, **GIVE** permission to Aspen Medical Group, Inc., to release medical information on my behalf, to the following person(s):

NAME		RELATIONSHIP
ADDRESS		
PHONE #	AGE	BIRTHDATE
DRIVERS LICENSE #	SOCIAL SECURITY #	
OTHER FORM OF IDENTIFICATION		

NAME		RELATIONSHIP
ADDRESS		
PHONE #	AGE	BIRTHDATE
DRIVERS LICENSE #	SOCIAL SECURITY #	
OTHER FORM OF IDENTIFICATION		

NAME		RELATIONSHIP
ADDRESS		
PHONE #	AGE	BIRTHDATE
DRIVERS LICENSE #	SOCIAL SECURITY #	
OTHER FORM OF IDENTIFICATION		

PATIENT SIGNATURE: ______________________________ DATE: ____________

PRINT PATIENT NAME: ______________________________ DOB: _____________

PATIENT RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPPA), this office has established procedures to make your identity and medical records more secure. Our only use of your personal information is for billing purpose and for proper medical treatment. We must have on record, a signed acknowledgement, that you have read your rights and responsibilities as a patient and that you understand them. Please contact the office staff if you have any questions.

PATIENT RIGHTS

- To receive service within a reasonable period of time
- To receive medically necessary services
- To be treated with respect and courtesy
- To receive all available information about your care and treatment, including risk and options
- To have your medical coverage explained to you
- To have all medical personal records treated confidential
- To participate in treatment decisions
- To refuse treatment
- To receive impartial access to treatment
- To receive a second opinion regarding any treatment plan
- To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges
- To request review of your medical record by the provider and to request corrections if necessary
- To be given information on how to file a complaint/grievance
- To formulate an Advance Directive if you have a life threatening illness or injury
- To provide, or have provided for you, an interpreter in your primary language

PATIENT RESPONSIBILITIES

- Having appropriate identification, insurance membership cards, and referral at the time of the appointment
- Keeping appointments or contacting this office in advance to cancel an appointment
- Fulfilling financial obligations at the time of service such as deductible or co-pay fees
- Providing complete and accurate information
- Following the health plan you and the medical provider agreed on
- Being considerate of others
- Providing legal documentation of guardianship of a minor being treated
- Providing a list of persons who may receive medical information about you, on your behalf, in an emergency

PATIENT SIGNATURE: _____ DATE: _____

PRINT PATIENT NAME: _____