Nathalie Michaud M.D. Family Medicine 2255 Ygnacio Valley Rd. Ste. V
Walnut Creek, CA 94598 Ph: 925.464.2624 F: 925.464.2694

BASS MEDICAL GROUP

PATIENT REGISTRATION

Patient Name: _____

Date Of Birth: _____Age: _____SSN#: _____-_____-_____ DL: _____

Patient Address: _____
Street Apt City State Zip Code

Patient Home Phone: _____Cell: _____Work: _____

Email Address: _____ Language: _____

Race: _____Hispanic? (Circle) Yes/ No **Religion: _____**

Marital Status: (Circle) Single Married Divorced Widowed **If Married, Spouse Name**: _____

Emergency Contact Name/Phone: _____**Relationship: _____**

INSURANCE INFORMATION

Please complete thoroughly. We will also obtain copies of front/ back of insurance cards

Primary Insurance Carrier: _____**Effective Date**: _____

Subscriber Name: _____ **DOB: _____Relationship**: _____
Self/ Spouse/ Parent

Secondary Insurance Carrier: _____Effective Date: _____
Please indicate if none- N/A

Subscriber Name: _____ **DOB: _____Relationship**: _____
Self/ Spouse/ Parent

If you have two or more Insurance carriers, please verify directly with your insurances that your benefits are coordinated to process claims in the insurance order provided.

THIRD PARTY INSURANCE INFORMATION

Is this work related? (Circle) Yes/ No **If yes, Date/ Type of Injury**: _____

Company Name: _____ **Claim/ Authorization #** _____

Contact/Adjuster Name: _____ **Phone Number**: _____

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PHYSICIAN/PHARMACY INFORMATION

Referring Physician Name/Number/City: _____

Primary Physician Name/Number/City: _____

Preferred Local Pharmacy Name/Number/City: _____

Mail Order Pharmacy Name/Number/City: _____

ACKNOWLEDGEMENTS

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payments or denial of insurance coverage. It is my responsibility to understand and personally verify that my insurance is contracted with this practice/doctor/provider, I am seeking services from. You have the right to request services by out of network providers by obtaining an NSA consent form for services in an Ambulatory Surgical Center and Hospital setting by agreeing to the financial/estimate amounts disclosed.

I hereby authorize BASS Medical Group to apply for benefits and submit insurance claims for reimbursement on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed. I also understand that if any insurance payments are sent to me directly, it is my responsibility to send to BASS Medical Group immediately upon receipt. I, the patient, or the patient's representative, understand that all medical doctors at BASS Medical Group are licensed and regulated by the Medical Board or California. I can verify this by contacting the Medical Board at (800) 633.2322 or via internet website: www.mbc.ca.gov. I further agree to pay collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

You acknowledge that you are the owner of the phone numbers (whether associated with a mobile, cell or landline) and email addresses that you provide to us. If you are not the owner, you represent that you are authorized by the respective owner(s) to authorize the use of those phone numbers and email addresses as described below, on the owner's behalf. You authorize us and any third party, such as our independent contractors, business associates, agents and/or affiliates, who we may authorize, to: (1) call you at any of the numbers that you provide to us, using an automatic telephone dialing system and/or using a recorded message upon being answered, or another similar method such as an artificial or pre-recorded voice; (2) text messages to you at any of the numbers that you provide to us; and/or (3) send email communications to you at any of the email addresses that you provide us; for any of the following purpose: confirming appointments, providing registration or clinical instructions, communicating about post-service follow up, telemarketing, billing, advertisements, advising you of special offers, events and services, communicating about your account, insurance and payments, and collecting debts that you owe to us. You do not have to give us permission to call, text or email you. Giving us permission to call, text, or email you is not required in order to receive services, to purchase any property or goods. You have the right to opt out of these types of communications.

Signing below grants us permission to proceed with these types of communications.

_____ _____ _____

Patient Signature, Parent or Legal Representative | Relationship to Patient | Date

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Today's Date: _____

Patient History Form

Name: _____ **DOB**: _____

Reason for the Visit: _____

Medications
Please list all current Medications, including vitamins

Name of Medication	Dose	Frequency

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Name: _____ **DOB:** _____

Allergies
Please list all drug allergies

Drug	Reaction(s)

Past Medical History
Please check whether you have or have had any of the following conditions

Diabetes	☐Yes ☐No	**High Cholesterol**	☐Yes ☐No
High Blood Pressure/Hypertension	☐Yes ☐No	**COPD/Emphysema**	☐Yes ☐No
Coronary Artery Disease	☐Yes ☐No	**Asthma**	☐Yes ☐No
Congestive Heart Failure	☐Yes ☐No	**Stroke**	☐Yes ☐No
Chronic Renal Failure	☐Yes ☐No	**Dementia (Alzheimer's)**	☐Yes ☐No
Sickle Cell Anemia	☐Yes ☐No	**Parkinson's Disease**	☐Yes ☐No
Atrial Fibrillation	☐Yes ☐No	**Hepatitis B**	☐Yes ☐No
Cancer	☐Yes ☐No	**Hepatitis C**	☐Yes ☐No
		HIV	☐Yes ☐No
		Rheumatoid Arthritis	☐Yes ☐No
		Gout	☐Yes ☐No
		Lupus	☐Yes ☐No

Type:
_____

Other:_____
_____
_____
_____
_____

Comments:_____
_____
_____
_____
_____
_____

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Name: _____ **DOB**: _____

Past Surgical History
Please list all prior surgeries

Surgery	Year	Surgery	Year

Family History
Please answer the following questions about your family members:

Father	☐ Alive ☐ Deceased	**Age/Age at death**	**Cause of death**
	Medical problems:		
Mother	☐ Alive ☐ Deceased	**Age/Age at death**	**Cause of death**
	Medical Problems:		
Sister	**Medical Problems:**		
Brother	**Medical Problems:**		
Family History:	**List any other relevant problems:**		

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Name: _____ **DOB:** _____

Social History

Alcohol	**Do you drink Alcohol?** **If yes, how often?** **Daily☐ Weekly☐ Monthly☐ Socially☐ Rarely☐**	
Drinks	**☐Beer ☐Wine ☐Liquor** **Amount?** **When was your last drink?**	
Tobacco Use	**Do you Smoke?** **If yes, how many packs per day?**	
	How many years did you smoke?	**Which year did you quit?**
Drug Use	**Do you currently use recreational drugs?** **Have you in the past?**	
	Have you ever used intravenous drugs?	
Caffeine Use	**If yes, what kind? ☐Coffee ☐Soda ☐Chocolate ☐Tea ☐Other** **How many cups per day?** **How many sodas per day?**	
Employment	**Occupation (past or present):**	
Social History	**Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced** **Who lives at home with you?** **Do you have children?** **If so, how many?**	
Miscellaneous	**Have you ever received a blood transfusion?** **☐Yes ☐No** **When?**	

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Name: _____ **DOB:** _____

Review of Systems
Please check whether you have any of the following problems, either now or recurrent:

Constitutional
Fever ☐Yes ☐No
Headache ☐Yes ☐No
Unexplained weight loss ☐Yes ☐No
Other: _____

HEENT
Runny nose ☐Yes ☐No
Difficulty hearing ☐Yes ☐No
Sore throat ☐Yes ☐No
Other: _____

Neurologic/Psychiatric
Numbness ☐Yes ☐No
Tingling ☐Yes ☐No
Weakness ☐Yes ☐No
Dizziness ☐Yes ☐No
Memory loss ☐Yes ☐No
Seizures ☐Yes ☐No
Anxiety ☐Yes ☐No
Spinal cord injury ☐Yes ☐No
Headache ☐Yes ☐No
Difficulty sleeping ☐Yes ☐No
Other: _____

Metabolic/Endocrine
Excessive thirst ☐Yes ☐No
Too hot ☐Yes ☐No
Too cold ☐Yes ☐No
Other: _____

Immunologic
Hay fever ☐Yes ☐No
Food allergies ☐Yes ☐No
Other: _____

Respiratory
Shortness of breath ☐Yes ☐No
Wheezing ☐Yes ☐No
Cough ☐Yes ☐No
Other: _____

Musculoskeletal
Joint pain ☐Yes ☐No
Back pain ☐Yes ☐No
Artificial joints ☐Yes ☐No
Other: _____

Cardiovascular
Chest pain ☐Yes ☐No
Irregular pulse ☐Yes ☐No
Heart attack ☐Yes ☐No
Heart valve problem ☐Yes ☐No
Other: _____

Hematologic
Easy bruising or bleeding ☐Yes ☐No
Blood clots in arms or legs ☐Yes ☐No
Anemia ☐Yes ☐No
Other: _____

Gastrointestinal
Abdominal pain
Nausea/vomiting
Indigestion/heartburn
Diarrhea
Constipation
Other: _____

Genitourinary
Back pain
Cloudy urine
Blood in the urine
Other:
_____

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Name: _____ **DOB**: _____

Vascular	**Dermatologic**
Cool extremity	Rash
Pain in limb	Boils/infections
Varicose veins	Itchiness
Other: _____	Other: _____

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BILLING AND FINANCIAL POLICY

The following sets forth the policies of Nathalie Michaud M.D./BASS Medical Group. Please review this information and sign where indicated below.

Insurance: I understand that it is my responsibility to furnish Nathalie Michaud M.D./BASS Medical Group with current, accurate insurance information at the time services are rendered and/or notify us in a timely manner of any changes in coverage, which may affect the payment of services already rendered. It is the responsibility of each patient to verify with their insurance if this practice and the physician you are seeing is a contracted provider. Nathalie Michaud M.D/BASS and/or its representatives will make every effort to assist you but Nathalie Michaud M.D./BASS will not be held accountable for understanding every insurance plan.

Co-Payments: I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have financial responsibility to pay these amounts. I understand that I will be provided with at least 2 statements for any balance due after insurance payment. Payment in full is due within 30 days of your first statement unless other arrangements have been made. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be final notice and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with those collection efforts.

Return Check Fee: I understand that a **$25.00** fee will be charged for all checks returned from the bank for non-sufficient funds.

Insurance Rebill Fee: I understand a **$20.00** fee will be charged if current insurance information is not provided thereby causing a delay in payment and requiring a 2nd insurance claim to be processed.

No Show and Cancellation Policy: We sincerely request 24-hour notice when canceling or rescheduling an appointment.

- I understand a **$30.00 NO SHOW/LATE CANCELLATION** Fee will be charged for all failed/late cancellations for standard office visits (15-minute appointments)
- I understand a **$60.00 NO SHOW/LATE CANCELLATION** Fee will be charged for all physicals and extended visits not canceled more than 24 hours in advance. (30 minute or longer time slots)

Disability Paperwork/forms: I understand that there is a **$25.00** fee (per form) to complete disability paperwork and/or other forms associated with my care.

I understand that the clinic may also take a verbal request from me over the phone to make a credit card payment on my account. I give authorization for the clinic to bill my card for the amount specified and acknowledge that verbal requests can only be made by the party responsible since no credit card information is kept on file.

My signature below confirms that I have read these billing policies and my financial obligations as pertains to the physicians of BASS Medical Group.

Signature of patient or legal guardian/guarantor_____Date_____

Print patient's name_____Relationship to patient_____

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BASS MEDICAL GROUP

HIPAA/NOTICE OF PRIVACY PRACTICES-Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is permitted use allowed by law. We have on file with these sources verification of the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose our health information without your prior written authorization.

Federal and state law allows us to use and disclose our patient's protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patient's health information. The purpose of this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

Patient Rights: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form
- You have the right to request in writing to inspect and /or receive a copy of your health information**. *Our office charges a reasonable fee to cover copying and mailing these records to you ; 10 cents per page.**
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.
- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

  ☐ **OK TO SPOUSE:**_____

  ☐ **OK TO ALL FAMILY MEMBERS: PLEASE LIST NAMES OF FAMILY MEMBERS:**

  _____

  ☐ **OK TO OTHER:**_____

  ☐ **OK TO LEAVE HEALTH INFORMATION ON ANSWERING MACHINE OR VOICEMAIL**

  ☐ **DO NOT RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF**

  ☐ **DO NOT RELEASE TO**_____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. Please contact our privacy officer at (925) 627-3424 with any questions.

Acknowledgement

This acknowledges that you have received and read a copy of our privacy practices notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records. This authorization and consent shall not expire and will last indefinitely unless modified.

Signature:_____ **Date:** _____

Patient's Name:_____**Date of Birth:**_____

If person signing is not the patient please provide:

Name:_____ Relationship to patient:_____

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HIPAA/NOTICE OF PRIVACY PRACTICES-Page 2

NOTICE OF PRIVACY PRACTICES FOR MINORS:

Consent for the care of a minor patient with authorized guardian

MINORS: We take patient privacy laws very seriously. The state of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they designate.

PATIENT INFORMATION:

Child's Name (Last, First, Initial)_____ DOB: _____

HomeAddress:_____City & State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____

In addition to the custodial parents of the above child, the following people have my permission to bring my child to Nathalie Michaud M.D. and authorize recommended care for my child.

Name:_____ Relationship:_____ Phone#_____

Name:_____ Relationship:_____ Phone#_____

OYes **O**No **It is OK to leave messages on my home or cell phone with results/personal health information.**

OYes **O**No **It is OK to leave appointment reminders on my cell or home phone for the minor patient.**

OYes **O**No **It is OK to disclose information about my child's care or treatment to any individual who states that they are a family member or friend.**

OYes **O**No **It is OK to disclose information about my child's care or treatment only to the following family members or friends named:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **DO NOT disclose information about my child's care or treatment to any individual, regardless of relationship or stated relationship.**

I authorize Nathalie Michuad MD and their designees to care for the minor patient named above and for whom I am responsible for. I certify that the information I have provided is true and correct.

Authorized person: (print name please)_____

Signature: _____Date: _____

Relationship to patient: _____ Phone #: _____