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: _____

Relationship: _____ Phone: _____

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

//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: _____

2637 Shadelands Drive
Walnut Creek, CA 94594
Ph: 925.627-3424 Billing Department
www.bassmerlicalgroup.com

BASS MEDICAL GROUP

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

2637 Shadelands Drive
Walnut Creek, CA 94598
Ph: 925.627-3424 Billing Department
www.bassmedicalgroup.com

BASS MEDICAL GROUP

BILLING AND FINANCIAL POLICY - pg 1

The following sets forth the policies of BASS Medical Group. Please review this information and sign were indicated below.

I understand that it is my responsibility to furnish 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.

I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25.00 NSF Fee. These amounts must be cleared with our financial office prior to your next appointment.

I understand that a cancellation fee of $25.00 may be billed directly to myself if a 48-hour cancellation notice is not provided to our office. All cancellation fees must be cleared with our financial office prior to your next appointment.

I understand that there is a $15.00 charge for being late past my appointment time.

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. BASS and/or its representatives will make every effort to assist you but BASS will not be held accountable for understanding every insurance plan.

I understand that there is a $25.00 fee (per form) to complete disability paperwork associated with my care.

I understand that the clinic will verify my insurance eligibility for surgery, but until claims are processed deductible amounts and co-insurance amounts prior to surgery cannot be determined. I further understand at a surgery copay may be collected upfront and applied to those fees. I further understand that ANY FEES I AM QUOTED ARE ESTIMATED based on I) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a 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 a final notice and may result in my account being sent to an outside collection service ifl 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.

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❖ I understand that the clinic will obtain the necessary authorizations prior to surgery. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for all charges not paid by my insurance carrier. This also applies if your insurance company delays payment Updated 1/3/19 over 90 days after billing or denial of insurance coverage. If your insurance company demands a refund of any monies paid to us, you become financially responsible for those charges.

❖ I understand that the clinic may also take a verbal request by 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 responsible party 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.

_____

Legal Signature

_____

Date

_____

Print Patient's Name

_____

Relationship to Patient

2637 Shadelands Drive
Walnut Creek, CA 94598
Ph: 925.627-3424 Billing Department
www.bassmedicalgroup.com

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NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check a license or to file a complaint, go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

Date	Patient Name (Type or print)
	Patient Signature
Date	Patient Representative's Name and Relationship (Type or print)
	Patient Representative's Signature

2637 Shadelands Drive
Walnut Creek, CA 94598
Ph: 925.350.4044
www.bassmedicalgroup.com

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

PATIENT HISTORY FORM

Date ____/____/____

Name _____

DOB _____

Referring Doctor _____

Primary Care Doctor _____

Reason for visit _____

How did you hear about us? _____

MEDICATIONS

Please list all current medications, including vitamins:

Name of medication	Dose	Frequency

ALLERGIES

Please list all drugs allergies:

Drug	Reaction

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 (e.g., Alzheimer's)	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Cancer		Hepatitis B	☐ Yes ☐ No
Type _____		Hepatitis C	☐ Yes ☐ No
Type _____		HIV	☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY

Please list all prior surgeries:

Surgery	Year	Surgery	Year

Name _____ DOB _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased Medical problems:	Age of death:	Cause of death:
Mother	☐ Alive ☐ Deceased Medical problems:	Age of death:	Cause of death:
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family H/O	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

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

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: 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 a permitted use allowed by law. We have on file with these sources, verification for 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 your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' 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 patients' health information. The purpose for 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 page 2 of this Form.

- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 2 of 3

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., *via* telephone text or email).

- 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.

  * Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent *via* Text, *via* email, 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.

- **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 may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: ____ AND DATE OF BIRTH: _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name, alternative address, phone number, & email address of Spouse, as applicable:** _____

  ☐ **OK to Family Members: Please list name(s), alternative address, phone numbers, & email addresses of Family Member(s), as applicable:** _____
  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities:**
  _____
  _____

BASS MEDICAL GROUP

HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 3 of 3

☐ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____

Email address: _____

IF PATIENT IS A MINOR, PLEASE STATE AGE: ____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:** _____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature:_____ Date:_____

Patient's Name:_____Date of Birth:_____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name:_____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.