PACIFIC FAMILY PRACTICE
PATIENT REGISTRATION

Last Name	First	MI
Street Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone

Name you wish to be called		
Social Security Number	Preferred Language	
Sex (M/F)	Email Address	DOB

How did you hear about our office?
- ☐ Friend ☐ Family ☐ Zoc Doc
- ☐ Referred by physician
- ☐ Internet? ☐ Yelp ☐ Google

Ethnic
- ☐ Latino or Hispanic ☐ Non-Latino or Hispanic
- ☐ Declined

MEANINGFUL USE

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other / Not Listed
- ☐ Prefer not to answer

Person to Contact in Case of Emergency:

Last Name	First	MI	Relationship	
Street Address	City	ST	Zip	Tel#

Employer:

Name	Position		Tel#
Street Address	City	ST	Zip

Spouse or Domestic Partner Employer:

Name	Position		Tel#
Street Address	City	ST	Zip

Other Family Members Seen at this Office:

Spouse/Domestic Partner		DOB
Child & DOB	Child & DOB	Child & DOB
Parent & DOB	Child & DOB	

PACIFIC FAMILY PRACTICE PAYMENT POLICY:
Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. With the advent of managed care, much questions you may have. We will be happy to provide a copy of this upon your request.
CO-PAYMENTS: All co-payments must be paid at the time of service. This payment is required by your insurance company. If you are unable to make this payment, we will add a $15 billing service charge to each statement we must now send to you to recover this payment.
NON-COVERED SERVICES: Please be aware that some and perhaps all of the services you receive may not be covered by your insurance. If this is the case, we will require payment from you for these non-covered services. Knowing your insurance benefits is your responsibility and any questions you may have about your coverage should be directed to your insurance company.
CLAIMS SUBMISSION: We will submit your claims to your insurance company and assist you in any way we reasonably can to help get these claims paid. If you do not have a current insurance card, payment in full for each visit is required until we receive your new card from you as we cannot bill your insurance company without this card. Please also be aware that the balance of your claim is ultimately your responsibility if the insurance company does not pay your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you and we will expect payment from you.
NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. Please keep us apprised of any address changes you may have so we can help ensure that you are receiving our statements.
MISSED APPOINTMENT: We reserve the right to charge $50 for missed appointments and appointments cancelled less than 24 hours. These charges are your responsibility and will be billed directly to you. Please help us to serve you better by keeping your scheduled appointments.
FORMS: Because of the time involved, your physician may need to charge $25 - $50 fee for all forms, applications or letters that need to be completed.

Our practice is committed to providing the very best treatment to our patients. Our prices are representative of the usual and customary charges for San Francisco. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________ Date ______________