Pacific Family Medical Group

Lisa Dwelle, MD
Michael Hendrick, MD
Heather Bone, NP-C

p. 831 375-4945
f. 831 375-4779

1900 Garden Road Suite 100 Monterey, California 93940

WELCOME TO OUR OFFICE! PLEASE COMPLETE THE FOLLOWING INFORMATION FOR YOUR CHART.

FULL NAME: _____

ADDRESS (INCLUDE CITY AND ZIP CODE)**:** _____

_____

HOME PHONE NUMBER: _____ **CELLULAR PHONE:** _____

WORK PHONE NUMBER: _____

(Please mark/place a star beside your preferred phone number)

Do you consent to receive text message alerts from the office?
Yes _____ *No* _____

E-MAIL ADDRESS _____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

LANGUAGE: _____ **RACE:** _____ **ETHNICITY:** _____

SOCIAL SECURITY NUMBER: _____

RELATIONSHIP STATUS (CIRCLE): SINGLE MARRIED PARTNERED DIVORCED WIDOW/ER YOUTH

INSURANCE NAME/ ID/ GRP. NO: _____

NAME & DATE OF BIRTH OF PERSON INSURED: *(if other than self)* _____

RELATIONSHIP TO INSURED: _____

PREFERRED PHARMACY: *(Pls. include name & city)* _____

PREFERRED LABORATORY: *(Pls. include name & city)* _____

EMERGENCY CONTACT INFORMATION: _____

(Please include names & phone numbers)

_____

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General Information For Patients

Greetings! We are board certified Family Medicine Physicians who are associated with the Community Hospital of the Monterey Peninsula. Our scope of practice includes primary care for preteens (10 years and above), adolescents, men and women with an emphasis on prevention.

Office Hours:

Dr. Hendrick:	Mondays – Fridays	9:00 am – 5:00 pm (break between 12:00 pm and 1:00 pm)
	Thursdays -	9:00 am – 5:00 pm (break between 12:00 pm and 1:30 pm)
Dr. Dwelle:	Mondays &	8:15 am – 2:45 pm
	Thursdays -	8:15 am – 2:45 pm
Nurse Bone:	Thursdays & Fridays	9:00 am – 5:00 pm (break between 12:00 pm & 1:00 pm)

Office Policies:

- There will be a $40.00 charge for all regular missed appointments or cancellations without a **24 hour** notice on the 2nd occurrence, $70 for annual exam appointments i.e. physical exams, women's exam.
- Payment (in full or co-payment) is due at the time of service. We accept cash, checks, debit or credit card. A $25.00 fee will be added for returned checks.
- Please allow **72 hours** for prescription refills. Please call your pharmacy first. They will contact us via fax with all refill requests.
- It is very important that we keep current and accurate information in your chart! You are responsible for giving us your most up-to-date insurance information. You are responsible for any and all charges for visits if your insurance information is incorrect or expired.
- Notify us of any changes in your medications, personal information, etc.

We greatly appreciate your understanding and assistance in these matters.

Please sign below as an indication of your agreement. Thank you.

Date: _____ Signature: _____

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PATIENT CONSENT FORM

I hereby give my consent for Pacific Family Medical Group (PFMG) to use and disclose protected health information (PHI) to carry out treatment, payment, and health care operations, as permitted by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The Notice of Privacy Practices has been provided to me by this office. I have reviewed/have the right to review the Notice of Privacy Practices. A revised Notice of Privacy Practices can be requested in writing to the privacy officer at the above address, in the event a revision occurs.

With this consent, PFMG, the doctors and office staff may call my home or alternate location and leave a message on an answering machine, voice mail, or with a family member in reference to my PHI, including appointment reminders, insurance items, payment balances, and clinical care (including lab or test results) unless otherwise specifically described here:

_____

_____

I have the right to request PFMG to restrict how my PHI is used or disclosed in carrying out treatment, payment, or operations. The practice, by law, is not required to comply with my request, however if it does, it is bound by this agreement.

I may revoke my consent in writing (except to the extent that the practice has already made in reliance upon my consent). If I do not sign this consent, or later revoke it, I am aware that the practice may decline to provide treatment to me.

MEDICATION AUTHORIZATION

☐ I authorize ☐ I do not authorize

my insurance company to provide PFMG information regarding medications that I am currently taking. This information will be transferred into my electronic medical records

RELEASE OF VACCINATION RECORDS

☐ I authorize ☐ I do not authorize

PFMG to share and access my vaccination records from the California Immunization Registry (CAIR).

Note: Leaving boxes unchecked means you're

Print name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

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BILLING AND INSURANCE POLICIES

Insurance Plans

Pacific Family Medical Group (PFMG) accepts many insurance plans. Please check with your insurance directly to confirm before your appointment if our physicians are listed as participating (in-network) providers with your insurance plan.

Co-pays

We collect the co-pay required by your health insurance when you arrive for your appointment. We accept cash, debit cards, personal checks, MasterCard and Visa.

Payments on day of Visit

On the day of your visit, we check with your insurance plan to determine if the costs of the visit will be your responsibility (and applied to your deductible with your insurance company) or will be paid for by your insurance. If today's costs are your responsibility, we collect them at the end of the visit today.

In some instances your insurance will pay for the visit, i.e. physical exams or preventive visits. In cases like these, we will not collect your co-pay or share of cost.

Submitting to Insurance and Balances

PFMG will submit your claim for your appointment directly to your insurance, and PFMG will bill you for any remaining balance after your insurance has paid its share.

Self-Pay

If you do not have any health insurance, we give a 25% discount to our usual fees. Fees are based on the level of complexity of the visit plus additional service. The complexity of the visit plus any other service given to you is determined at the end of the visit by the physician. Any estimates given by the staff are only possible charges, and are not the actual total. You are welcome to review our fee list prior to your appointment.

Payment Plans

Special arrangements may be made for extended payment plans. We encourage you to discuss payment plans with Marissa, our billing coordinator.

Past Due Balances

All fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due. In this case, we will make every effort to contact the person responsible for the balance, and arrange a payment schedule. However, if no effort is made to pay the balance due, it may be sent to a collection agency. In this situation, the responsible person and family will be asked to seek medical care elsewhere.

Refunds

In the event that your account has a credit, it will be refunded to you or will be used on your next visit if you choose to.

Please sign below as an indication of your agreement. Thank you.

Date: _____ Signature: _____