St. Joseph's Medical Group of Stockton

Joint Notice of Privacy Practices for Health Information (NPP) Acknowledgment Form

Patient Name: _________________________ MRN: _____________________

Effective April 14, 2003, the law requires St. Joseph's Medical Group provide a patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such.

Acknowledgment
Signature: _________________________________ Date: ___________________

If not by patient:

Print name: ____

Relationship to Patient: _________________________________

For Official Use
I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

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ST. JOSEPH'S MEDICAL GROUP
CREDIT POLICY

Patient's Name: ______________________________ MRN: _________________

We at CHW Medical Foundation are committed to providing the highest level of professional medical care and personal service. By selecting our medical group you have expressed confidence in our ability to meet this commitment.

PAYMENT PROCEDURE

For every commitment there is an obligation. At CHW Medical Foundation we are committed to providing quality medical care and service. Conversely, we feel it is the guardian/patients responsibility to meet their financial obligation.

As we see patients from many Insurance Plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. While it is our intention to assist you, it is still your responsibility to insure that all services rendered by CHW Medical Foundation on your behalf are paid in full within thirty (30) days of the statement date. In some instances, CHW Medical Foundation can not bill your insurance carrier for you in such cases as Auto Accidents, Insurance Liens, etc. However, you will be provided with all of the information necessary to submit a claim to your insurance company.

Depending on your insurance coverage, at the time of your visit to the Clinic, you may be asked to make a deposit on your account prior to seeing a physician. Deposits will be applied toward charges incurred but may not represent payment in full for services which are rendered. Additional charges may be warranted because of our x-ray facilities, supplies, or more complex physician services as required for treatment.

The patients financial responsibility may include co-payments, co-insurance, and services not approved or paid by your insurance carrier. This financial responsibility also applies if your insurance carrier is not contracted with CHW Medical Foundation.

It is important that you bring proof of insurance each time you visit the Clinic. Failure to do so may result in your not being seen or being required to make a full payment at the time services are rendered. CHW Medical Foundation accepts cash, check, major credit cards and ATM.

Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, or phone number) has changed since your last visit.

The above and patient registration information is provided for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation including employment verification.

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medi-Cal, Government, and any other third party benefits made on my behalf and/or on behalf of all members covered on my insurance plan be made directly to St. Joseph's Medical Group for services furnished by that provider.

I authorize the release of medical information about me needed to determine benefits or benefits payable to related services. I permit a copy of this authorization to be used in place of the original.

We understand that insurance coverage is very confusing to many people, and we are committed to helping you with any questions you may have.

Please feel free to call Patient Account Services directly at (916) 379-2848.

I have read and understand the policy stated above.

____ __________________
Account Guarantor / Responsible Party’s Signature Date

ST. JOSEPH'S MEDICAL GROUP OF STOCKTON, INC.

SIGNATURE ON FILE

I understand that payment of authorized Medicare benefits be made either to me or on my behalf to (provider/supplier listed) for any services furnished me by the listed (provider/supplier). I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the change determination of the Medicare carrier as full charge, and the patient is responsible only for the deductible, coinsurance, or non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

DATE: ____

PATIENT NAME: ____

PATIENT MEDICARE ID#:_____________________________________

PATIENT'S SIGNATURE: ___________________________________

PROVIDER: ______________________________________
3132 W. MARCH LANE
STOCKTON, CA 95219
(209) 475-5500 OFFICE
(209) 475-5503 FAX