Patient Registration

Patient

Last	First	M.I.	Gender	Date of Birth / /	Marital Status S M S D W
Street Address	City	State	Zip	Home Number	Cell Number
Employer	Employer Address				Employer Phone Number
Primary Care Provider Name	Primary Language	Drivers License Number		Email Address	

Spouse

Name				Social Security Number	Date of Birth / /
Street Address	City	State	Zip	Driver's License #	Phone Number
Employer	Address	City	State Zip		Employer Phone

Responsible Person

If patient is under 18 years of age or under guardianship, please complete the following section:

Mother/Guardian Name (*circle one*):				Social Security Number	Date of Birth / /
Address (if different from above)				Home Number	Cell Number
Employer	Address	City	State Zip		
Employer Phone	Driver's License Number (used for verification in communication):				
Father/Guardian Name (*circle one*):				Social Security Number	Date of Birth / /
Address (if different from above)				Home Number:	Cell Number:
Employer	Address	City	State Zip		
Employer Phone	Driver's License Number (used for verification in communication):				

Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

If there are any COURT-MANDATED custody/visitation orders limiting access by a parent, *please provide a copy of the **legal order.***

Emergency

Friend or relative to contact in case of an emergency:

Name:		Relationship	
Address		Day Time Number:	Evening Number:

Insurance

Primary Insurance	Name of Insurance	Group/Policy Number	Member Number	Effective Date
	Subscriber's Name	Relationship	Subscriber's SSN	Subscriber's Date of Birth / /
Secondary Insurance	Name of Insurance	Group/Policy Number	Member Number	Effective Date
	Subscriber's Name	Relationship	Subscriber's SSN	Subscriber's Date of Birth / /

Privacy

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. **ACKNOWLEDGEMENT OF RECEIPT:** I acknowledge receipt of the *Notice of Privacy Practices* of Magan Medical Clinic, Inc. Initial: _____

Signature: _____ ***Relationship:*** _____ ***Date:*** _____

MAGAN MEDICAL CLINIC
420 W. Rowland St., Covina CA 91723
Patient Registration

APPT. LABEL

magan medical clinic, inc.

Name: _____

The government has recently requested that health care organizations capture demographic data on all patients to include Language, Race, and Ethnicity to help our nation improve the quality, safety, and efficiency of patient health care.

Race:
Select ***ONE*** of the following categories:

☐ **American Indian or Alaskan Native** – All persons having origins in any of the original peoples of North America.

☐ **Asian** – All persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent.

☐ **Black of African American** – All persons having origins in any of the Black racial groups of Africa.

☐ **Native Hawaiian or Pacific Islander** – All persons having origins in any of the Pacific Islands.

☐ **White** - All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

☐ Unknown

☐ Declined

Ethnicity:
Please select one:

☐ No, I am not **Hispanic or Latino.**

☐ Yes, I am **Hispanic or Latino**: A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

☐ Unknown

☐ Declined

magan medical clinic, inc.

Nombre: _____

El gobierno ha solicitado recientemente que las organizaciones de salud capturen los datos demográficos de todos los pacientes incluyendo el idioma, la raza y el origen éthico para ayudar a nuestra naciòn mejorar la calidad, seguridad y eficiencia de la atenciòn médica de los pacientes.

Raza – Por favor eliga uno:
Por favor eliga uno:

☐ **Indio Americano o Nativo de Alaska** – Una persona que tiene origenes en cualquiera de los pueblos del origin de Norte y Sudamérica (incluyendo América Central) y que mantiene afiliaciòn triabal o un archivo adjunto con la comunidad.

☐ **Asiático** – Una persona que tiene origenes en lejano oriente, el sudeste de Asia, o el subcontinente indio, incluyendo, por ejemplo, Vietnam, Caboya, China, India, Japòn, Corea, Malasia, Pakistán, las Islas Filipinas, o Tailandia.

☐ **Negro o afròamericano** – una persona en cualquiera de los grupos Negros raciales de África.

☐ **Nativo de Hawai u otra isla del Pacifico** – una persona que tiene orgienes en cualquiera de los pueblos originales de Hawaii, Guam, Samoa u otras islas del Pacifico.

☐ **Blanco** – una persona que tiene origenes en cualquiera de los pueblos originales de Europa, el Medio Oriente o Africa del Norte.

☐ Desconocido

☐ Yo opto por no responder

Origen Ètnico:
Por favor eliga uno:

☐ **Hispanic or Latino**

☐ No **Hispanic or Latino**

☐ Desconocido

☐ Yo opto por no responder

Conditions of Services

CONSENT TO PHOTOGRAPH

I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures, for purposes of my diagnosis or treatment or for the clinic's operations, including peer review and education or training programs conducted by the clinic. Initial _____

ASSIGNMENT OF BENEFITS

The undersigned authorizes, whether he/she signs as agent or the patient, direct payment of insurance benefits (otherwise payable to or on behalf of the patient) to the Clinic. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. It is understood by the undersigned that he he/she is *financially responsible* for charges not paid pursuant to this assignment.

Patient Name _____ Date _____

Signature (Responsible Person) _____ Relationship _____

magan medical clinic, inc.

Patient Name_____ Date_____

Patient Financial Responsibility Form

Thank you for choosing Magan Medical Clinic as the health care provider for you and your family. We are pleased to participate in your health care needs. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies which are as follows:

Self-pay patients (no insurance)

All cash patients and those who present without valid insurance information are considered "self-pay". All self-pay patients are required to pay for their visit in full at time of service; you will be eligible for a 10% cash discount on any bill over $120.00 for adult medicine, specialty or urgent care or $100.00 for pediatrics that is paid in full at the time of the visit.

Please be prepared to pay a deposit with the front desk personnel at the time of your visit.

- Deposits: All deposits made will be applied to toward any charges for services rendered.
  - **A deposit of $100.00 will be required prior to being seen in the Urgent Care, specialty and adult medicine departments.**
  - **A deposit of $80.00 will be required prior to being seen in the pediatrics department. A 25% cash discount will be given on REQUIRED childhood immunizations.**
- Price quotes: It is understood that any price quote provided is based upon available information at the time of the quote. You will be responsible for any additional charges that may be added to the final billing according to the level of the visit, additional diagnostic testing, medication or other services ordered.

Insurance coverage:

It is your responsibility to be aware of your insurance coverage, including but not limited to ensuring that our clinic is in your network or you are assigned to one of our physicians, policy provisions, exclusions and limitations, and authorization requirements. This information can be obtained by contacting your insurance carrier. We attempt to verify your coverage at the time of your visit. However, if your coverage is not in effect at the time of the visit, you will be responsible for any payments due.

- Authorizations and pre-certifications: do not guarantee payment in full for the service provided.
- If your insurance does not respond within 2 billing periods, your bill will be sent to you for payment or follow up with your insurance carrier. If you need assistance, please contact our billing department at 626-331-6411 ext 1353
- Changes to your insurance must be reported to our staff promptly, to avoid financial responsibility.
- If your insurance sends you our payment, please forward the check to us immediately. Failure to do so may result in your account becoming delinquent.

Co-pays, co-insurance, deductibles:

- Patients or guarantors are responsible for the payment of co-pays, co-insurance, and deductibles. **Your co-payment is due at time of service.**

Fees:

Patients may incur and are responsible for the payment of additional charges at the discretion of Magan Medical Clinic, as allowed by law. These charges may include but are not limited to:

- No show fee: $25.00 Charge for missed appointments without 24-hour notice
- Nonpayment of co-pay fee: $25.00 charge for uncollected co-pay
- Non-sufficient funds fee: $25.00 Charge for returned checks in addition to the amount of the check
- Form fee: $25.00 charge for completion of forms (DMV, school, work, etc.)
- Medical Records fee: Charge dependent on number of pages copied.
- Any costs associated with collection of patient balances
- Charge for afterhours visits

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Non Covered services:
You will be held responsible for any service or treatment deemed not payable and any other patient responsibility indicated by your insurance carrier or our financial policies, which are not otherwise covered by insurance.

Billing:
Statements are mailed out on a 28-day cycle; Payment is expected 15 days from receipt of your statement. Payment plans may be available, please contact our business office at 626-331-6411 ext. 1353.

Failure to pay:
- Past due account: Will hinder your ability to make appointments.
- Delinquent account: Should your account be placed for collection review you will be discharged from Magan Medical Clinic. You are responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency.
- Bankruptcy: If you file bankruptcy you and your family will be discharged from Magan Medical Clinic.

Guarantor:
Any patient over the age of 18 or an emancipated minor will be held financially responsible for all charges incurred.
- Divorce or separation: In the case of divorce or separation, the parent present will be responsible. It is that parent's responsibility to collect from the other parent if they are to pay all of part of the cost, without the inclusion of Magan Medical Clinic.
- Under 18: Parents or guardians are financially responsible for their minors or dependents.

Prompt payment:
Just as we make every effort to accommodate you when you are in need of medical care, we ask that you make every effort to pay your bill promptly. Payment is due at the time services are rendered or within 15 days of receipt of a statement from our billing office.

Refunds:
A refund is issued when an overpayment has been identified. However, if you make a payment that results in a credit on your account, you authorize Magan Medical Clinic to apply the overpayment to any accounts for which you are financially responsible, including your account, a member of your family's or dependent's account. Any remaining balance will be returned to you.

Workers compensation:
We do not accept any worker's compensation cases.

Medicare Patients:
Medicare may not cover some of the services that your doctor recommends. You will be asked to sign an ABN form to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. Please read the ABN carefully.

Additional Services:
All lab tests are subject to being sent to an outside facility which may result in additional third party charges. The lab is independent from Magan Medical Clinic; we do not bill on their behalf. Please contact the number on your lab bill for any billing inquiries.

Communication:
By signing below, you authorize Magan Medical Clinic personnel to communicate with you via mail, phone, answering machine and or e-mail according to the information provided on the registration form you completed.

I have read, understand and agree to the terms and provisions of this Patient Financial Responsibility form. I understand that these policies can be changed at any time by Magan Medical Clinic without notice.

Patient/Guardian Signature	Patient/Guardian Name (please print)	Date

VERBAL COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE

Name: _____ DOB: _____

This form DOES NOT cover access to or release of medical records. This form may be used to document those individuals you want to communicate with providers and staff at Magan Medical Clinic, Inc., in person or on the phone, in regards to the coordination or payment for your care. For access or copies of records to one of the individuals you designate, you must complete an Authorization for Disclosure of Protected Health Information for each separate disclosure or have an effective Advance Healthcare Directive or other valid legal document on file.

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name:	Relationship to Patient:	Date of Birth:	Type of Information (Initial)			
			ALL	Schedule/ Appoint.	Medical	Billing/ Insurance
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*
			Initial	*Initial*	*Initial*	*Initial*

Please describe any specific Instructions or Limitations: _____

_____

_____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request with a copy of this form to *The Health Information Services Department – Release of Information* at the address below.

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420 W. Rowland St., Covina CA 91723

Authorization For Verbal Communication

APPT. LABEL

ADVANCE HEALTH CARE DIRECTIVE STATUS

I have been informed of my right to formulate advance directives concerning health care decisions, and I have been provided with information regarding the execution of an Advance Health Care Directive.

Please check one of the following:

☐ **I have** completed an Advance Health Care Directive and have provided a copy for inclusion in my medical record.

☐ I will provide a copy of my previously executed Advance Health Care Directive to Magan Medical Clinic for inclusion in my medical record.

☐ **I have not** executed an Advance Health Care Directive and I am not interested in further information.

☐ I am interested in formulating an Advance Health Care Directive and will discuss my options with my primary care provider at my next appointment.

Patient Signature: _____ Date: _____

Received By: _____ Date: _____