

INSURANCE AND PAYMENT INFORMATION

PATIENT INFORMATION

Patient Name (Last, First, Middle):	Date of Birth (MM-DD-YYYY):	Last 4 Digits of Social Security #:	
_____	_____	_____	
Home Address:	City:	State:	ZIP Code:
_____	_____	_____	_____
Phone Number:	Communication Preference: <input type="radio"/> Mail <input type="radio"/> Phone <input type="radio"/> No Preference		
_____	_____		
Relationship to Patient:	Phone Number:	Primary Physician:	Referring Physician:
_____	_____	_____	_____

PARENT (OR GUARDIAN) INFORMATION

Parent 1 (Last, First, Middle):	Date of Birth (MM-DD-YYYY):	Last 4 Digits of Social Security #:	
_____	_____	_____	
Driver's License #:	Relationship to Patient:	Employer:	
_____	_____	_____	
Work Address:	Work Phone:		
_____	_____		_____
Parent 2 (Last, First, Middle):	Date of Birth (MM-DD-YYYY):	Last 4 Digits of Social Security #:	
_____	_____	_____	
Driver's License #:	Relationship to Patient:	Employer:	
_____	_____	_____	
Work Address:	Work Phone:		
_____	_____		_____

INSURANCE INFORMATION

Primary Insurance:	_____		
Address:	_____		
Policy Number:	Subscriber Name:	_____	
_____	_____	_____	
Secondary Insurance:	_____		
Address:	_____		
Policy Number:	Subscriber Name:	_____	
_____	_____	_____	

Your signature below confirms that the information submitted above is true and correct to your knowledge and that you have read, understood, and accept our Insurance, Payment, and Other Terms on a separate page.

Patient's Signature: _____ **Date:** _____

Insurance, Payment, and Other Terms

AUTHORIZATION TO RELEASE INFORMATION FOR BILLING

I authorize the Genetics Center and its medical affiliates to release any information acquired in the course of my examination and treatment to my insurance company for authorization and billing purposes.

AUTHORIZATION TO RELEASE PAYMENT(S) TO GENETICS CENTER

I irrevocably assign and transfer insurance payment(s) directly to the Genetics Center.

INSURANCE ELIGIBILITY

I certify that I am eligible with my insurance company. I understand that if this is not true or if I am not eligible for some or all of the Genetics Center services under the terms of my insurance contract, I am liable for any and all charges for services rendered. Also, if I am not eligible, I agree to pay in full for all services rendered within thirty days of receiving a bill from the Genetics Center.

INSURANCE AND PAYMENT TERMS

I acknowledge that all medical bills are due and payable at the time services are rendered. However, as a courtesy to me the patient, Genetics Center will submit my claim to my insurance company for me. I understand that my insurance coverage is a contract between me and my insurance carrier. If it is my desire to have Genetics Center bill my insurance carrier for these services, I will present my insurance card.

I also acknowledge that **all co-pays and unmet deductibles are due and must be paid at the time of service.** In certain cases, Genetics Center may also require some deposit in advance. If my insurance company pays more than was collected, Genetics Center will promptly reimburse me that amount of the deposit. In some cases, my insurance will only cover a portion of the fees. If I have made an initial payment, it will then be applied to my balance.

If Genetics Center does not receive payment from my insurance carrier within 60 days from the date of my service, Genetics Center may look to me for payment in full. A monthly 1.5% service charge will be added to balances over 30 days old, and a \$10 statement fee will be added to balances over 60 days old. **The charges for Genetics Center services are ultimately my responsibility.**

California Senate Bill (SB) 1061 Notice: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

BENEFITS AND COVERAGE CHECK IS SUBJECT TO CHANGE

Genetics Center cannot accept responsibility for any differences between what was quoted to them by my insurance during their courtesy benefits and coverage check (copay, deductible, etc), and the final benefit determination performed by my insurance when my claim is processed. Therefore, I may owe a different amount than what was quoted to me prior to services.

ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTORS

I acknowledge that some providers involved here are not employees, but are independent contractors, specifically including the sonographers and perinatologists.

ACKNOWLEDGEMENT OF POTENTIAL BILLING BY OTHER PROVIDERS

I acknowledge that there could be other providers involved, such as ultrasound, hospital, perinatologist, etc., which will have their own billing.

AUTHORIZATION TO RECEIVE VOICE MESSAGES

I authorize the doctor and/or facility and/or staff to identify themselves as being from Genetics Center when calling to leave a message regarding my appointment, results, or other medical information on any answering device or with another person answering the phone

NOTICE OF OPEN PAYMENTS DATABASE

To comply with Assembly Bill (AB) 1278, I acknowledge receiving the required notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Genetics Center's Notice of Privacy Practices.

AUTHORIZATION TO RECEIVE TEXT MESSAGES

[Yes No] I expressly consent and authorize receipt of text messages from Genetics Center at the telephone number you provide for appointment reminders and general information related to my health care treatment, and I understand that I can opt-out at anytime.

My signature confirms that I have read, understand, and accept these terms.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____
(or parent if minor)



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No-Show and Cancellation Policy

We feel that our patient's time is valuable. When your appointment is made, time is reserved, your records are prepared, and certain staff is assigned to serve you. Please remember that your appointment is reserved exclusively for you.

An appointment cancellation or rescheduling made with less than 24 hours notice (one business day), or a no-show, significantly limits our ability to make the appointment available for another patient in need. Please be courteous and call our office promptly if you are unable to keep your appointment.

- **Patients who fail to show to their scheduled appointment or do not notify the office of cancellation more than 24 hours of their scheduled appointment shall be subject to a "No Show/Cancellation" fee of \$50. In the event of an emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.**
- As a courtesy, we make text message and/or appointment reminder calls a day or two in advance. This policy still remains in effect if a text message, reminder call, or voicemail is not received.

Your signature below indicates that you have read and understand the above.

Patient Name: _____

Patient Signature: _____ Date: _____