PATIENT INFORMATON *Certified Medical Group, Inc.*

Are you a new patient in this office: [ ] Yes [ ] No If no, date last seen _____
[ ] Mr. [ ] Mrs.
[ ] Miss [ ] Ms. Patient's name _____
First Middle Initial Last
Birth date _____ Age _____ SSN _____ [ ] Male [ ] Female
[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widow/er Maiden name _____ _____

Home phone ( ) _____ Cell ( ) _____

Mailing address _____ City _____ State _____ Zip _____

Home address _____ City _____ State _____ Zip _____
[ ] Right handed
[ ] Left handed Do you need an interpreter [ ] Yes [ ] No Religious preference _____

Who referred you to this office _____

Personal physician _____
Do you wish your personal physician to receive a copy of your office reports? [ ] Yes [ ] No

Patient's employer _____ Work phone ( ) _____

Work address _____ Occupation _____

Spouse's name _____ Birth date _____ SSN _____

Spouse's employer _____ Work phone ( ) _____

Spouse's work address _____ Occupation _____

Person to contact in an emergency (Not residing at your address) _____ Phone _____

Address _____ City _____ State _____ Zip _____

Reason For This Visit

[ ] Illness [ ] Injury [ ] Auto accident [ ] Personal Injury [ ] Job Related

How injury occurred? _____ Date of injury or illness _____

Where injury occurred?_____ Body part affected _____

How do you intend to pay? [ ] Cash [ ] Check [ ] Insurance [ ] Medicare [ ] Medi-Cal [ ] Credit card [ ]

Allergies to Medication

List allergies to medication _____

Primary Insurance Information

Insurance company name _____ Effective date _____

Address _____

Insured's name _____ Relationship to patient _____

Insured's SSN _____ Insured's date of birth _____

ID/Certificate number _____ Group number _____

Secondary/Supplemental Insurance

Insurance company name _____ Effective date _____

Address _____

Insured's name _____ Relationship to patient _____

Insured's SSN _____ Insured's date of birth _____

ID/Certificate number _____ Group number _____

Insurance & Records Release Authorization

I hereby authorize directly to *Certified Medical Group, Inc.*, all surgical and medical benefits otherwise payable to me for services performed. I also authorize *Certified Medical Group, Inc.* to release all information necessary to secure the payment of benefits.

Signed _____ Date _____

Over →

Certified Medical Group, Inc.
Board Certified Surgeons
125 Mall Drive, Suite 301
Telephone (559) 584-3000 • Fax (559) 583-8456

D. Lancy Allyn, M.D.
Board Certified Orthopedic Surgeon

Greg Schellack, O.D.
Orthopedic Surgeon

FINANCIAL AGREEMENT AND POLICY

New or established patients, unless seen as emergencies, are expected to pay for initial visits and x-rays in full on the day of service unless covered by an insurance plan. You are responsible for payment of any deductible, percentage, or co-payment not covered by the insurance at the time of visit.

If this is not possible, and your total bill exceeds your ability to pay in a short period of time, please discuss financial arrangements with the Billing Department or Office Manager. Prolonged payment plans are time consuming and costly to us. If necessary, we would prefer that you arrange a loan with a financial institution, or a service charge of 1.5% (annual percentage rate 18%) may be added. Master Card or Visa may be used for payment. You may call the Billing Dept. (559-585-6868) and authorize them to apply a payment using your credit card or mail the authorization found on the monthly statement to the Billing Department.

Canceled or broken appointment without 24-hour notification may be billed for full visit costs. While it is distasteful to turn accounts over to collection agencies, experience has shown this to be necessary on occasion. Certified Medical Group, Inc. shall be entitled to reimbursement of attorney and/or court fees incurred to collect charges. Please be assured that accounts will only be turned over to the collection agency after ample notice, usually not before three (3) months and not if goodwill is exhibited and some type of payment program satisfactory to this office is arranged.

If this is a work-related injury and your treatment has been authorized by the worker's compensation insurance company, you will not be responsible for payment. In the event any services are denied, you will be responsible for payment.

I have read, understood and accept the above financial agreement and policy in its entirety.

_____ _____

Patient or Responsible Person **Date**