REGISTRATION FORM

PATIENT INFORMATION

o Mr. o Mrs. o Miss	Last Name	First Name	Middle	o Male o Female
Home Address (Number and Street)			Mailing Address (if different)	
City	State	Zip	City	State Zip
Primary Phone ( )	Cell Phone Ext.#( ) ( )		Date of Birth	Patient's Social Security Number -- --
Work Phone ( )	Ext#( )		Ethnicity: Preferred Language:	Race:
In Case of Emergency Notify	Relationship to Patient	Primary Phone Ext.# ( ) ( )		Secondary Phone Ext# ( ) ( )
In Case of Emergency Notify	Relationship to Patient	Primary Phone Ext. #( ) ( )		Secondary Phone Ext# ( ) ( )

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT

o Mr. o Mrs. o Miss	Last Name	First Name	Middle	Relationship to Patient Home Phone ( )
Billing Address (if different from Patient's)		City	State	Zip Code
Employed By		Ethnicity: Race: Preferred Language:		Work Phone Ext. #( ) ( )
Employer Address (Number and Street)		Guarantor Date of Birth:		
City	State	Zip Code		

OTHER IMMEDIATE FAMILY MEMBERS SEEN AT SCP

Spouse: Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings: Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings: Last Name	First Name	Middle	o Male o Female	Date of Birth
Siblings: Last Name	First Name	Middle	o Male o Female	Date of Birth

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Group Number	Subscriber I.D.
Subscriber's Name: Subscriber's Address:	Subscriber's Date of Birth	Relationship to Patients

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company	Group Number	Subscriber I.D.
Subscriber's Name: Subscriber's Address:	Subscriber Date of Birth	Relationship to Patients

PLEASE TURN SHEET OVER FOR CREDIT INFORMATION AND SIGNATURE

PATIENT'S NAME _____

We here at Sierra Care Physicians 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. Our physicians and staff wish to welcome you and thank you for choosing Sierra Care Physicians.

PAYMENT PROCEDURE

Your clear understanding of our financial policy is important to our professional relationship. All patients are required to complete our patient information form on an annual basis regardless of the information not having changed.

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

As we see patients with many insurance plans, it is impossible for us to know all the covered benefits. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered by Sierra Care Physicians on your behalf are paid in full within thirty (30) days of the statement date. We cannot bill your insurance carrier for third party claims. However, you will be provided all of the information necessary to submit a claim to your insurance company.

Co-payments, co-insurance, deductibles and non-covered services are due at time of service. This financial responsibility also applies if your insurance carrier is not contracted with Sierra Care Physicians. Sierra Care Physicians will bill non-contracted insurances one (1) time as a courtesy to you, however, the patient is responsible for all charges and must pay any charges not paid by the non-contracted insurance.

Proof of Identity: I understand that I am required to provide photo identification at every visit for Sierra Care Physician's staff to verify my identity as mandated by Federal law.

It is important that you bring proof of insurance each time you visit. Failure to do so may result in your not being seen or you being required to make a full payment at the time services are rendered.

Forms of Payment: We accept cash, checks, Visa and Master cards and Care Credit. *Checks should be made payable to Sierra Care Physicians. A $25.00 fee will be charged for all returned checks.*

Collections Procedure: If your account is over ninety (90) days old you will receive a letter stating you have fifteen (15) days to pay your account in full. At this point partial payments will need to be negotiated with the billing department. Please be aware if your balance remains to be unpaid your account will be referred to an outside collections agency. In addition you may be subject to discharge from the practice. I agree that I will be liable for any attorney fees and costs in the event of unpaid balances being sent to collections that are deemed necessary by Sierra Care Physicians.

No Show Fee: We ask that you give us a twenty-four (24) hour notice if you are unable to make your appointment. Failure to give less than a two (2) hour notice for an appointment will result in **a No Show Fee of *$40.00.***

Photo Permission: By signing below you are giving permission for a photo to be taken by SCP and placed in your chart.

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 our Billing Department directly at: (530) 272-9788. Phone hours are 9:00 to 12:00 and 2:00 to 4:00, Monday through Friday.

X_____ _____

SIGNATURE and Print Name Account Guarantor/Responsible Party Today's Date

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to the Sierra Care Physicians and I am responsible for any non-covered services, including services statutorily not covered by Medicare, Medi-Cal, or other government programs. I also authorize the release of any information required for the processing of claims.

I certify that, to the best of my knowledge, the patient registration information is current.

I authorize the creditor or his agent to make a credit investigation, including employment verification.

X_____ _____

SIGNATURE and Print Name Account Guarantor/Responsible Party Today's Date