Rancho Wellness
YOUR MEDICAL HOME

Rancho Wellness - New Patient Registration Form

PATIENT INFORMATION

Patient's last name:	First name:	Middle name:	
Mailing address:	City:	State:	ZIP code :
Home phone no.: -	Cell phone no.: ( ) -	Work phone no.: ( )-	Patient Email:
Patient Date of Birth:	Patient Age:	Patient Sex: M F	Marital Status: single married divorced widowed other
Social Security no.: - -	Employer Name and Address:		
If patient is a senior with a legal Power of Attorney or a minor, please give POA/guardian/parent names and specify relation to patient:			

IN CASE OF EMERGENCY

Name of emergency contact person:	Relationship to patient:	Home phone no.: ( ) -	Work phone no.: ( ) -
Mailing address:	City:	State:	ZIP code:

INSURANCE INFORMATION

Name of primary insurance:	Policy subscriber's name, if not patient:	Policy subscriber's date of birth:
Policy Number:	Policy Effective Date:	
Patient's relationship to subscriber: Self Spouse Child Other, please specify:		
Name of secondary insurance (if applicable)	Policy subscriber's name, if not patient:	Policy subscriber's date of birth:
Patient's relationship to subscriber: Self Spouse Child Other, please specify:		

RESPONSIBLE PARTY (GUARANTOR)

The guarantor is the person responsible for the patient's bill. If the patient is responsible for his/her own bill, please skip the next section. If the patient is a minor (under the age of 18), the parent or guardian bringing the patient to the visit is usually the guarantor for the patient.

Gurarantor's last name:	Guarantor's first name:	Guarantor's middle name:	
Guarantor's mailing address, if different from patient:	City:	State:	ZIP code:
Guarantor's phone number: ( ) -	Relationship to patient:	Guarantor's date of birth:	Guarantor's Social Security No.: - -

OTHER INFORMATION

Pharmacy name:	Pharmacy location:	Pharmacy phone no: ( ) -

How did you hear about this office, or who referred you here?

May we notify you of appt./test results at the e-mail address listed above Yes No

May we leave messages of test results on your answering machine?	Yes	No	May we notify you of appointments at this mailing address?	Yes	No
May we leave voicemail messages of appointments on your answering machine?	Yes	No	May we notify you of test results at this mailing address?	Yes	No

Your Health Information Rights

The health and billing records we maintain are the physical property of the AFP. The information in it, however belongs to you. You have a right to:

The health and billing records we maintain are the physical property of the AFP. The information in it, however belongs to you. You have a right to:

• Request restriction on certain uses and disclosures of your health information by delivering the request to AMG's office—we are not required to grant the request, but we will comply with any request granted;

• Obtain a paper copy of the current Notice of Privacy Practices for protected health information ("Notice") by making a request at AFP's office;

• Request that you will be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to AFP's office;

• Appeal a denial of access to your protected health information, except in certain circumstances;

• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to AFP's office. We may deny your request if you ask us to amend information that:

• Was not treated by us, unless the person or entity that created the information is no longer available to make the amendment;

• Is not part of the health information kept by or for AMG;

• Is not part of the information that you would be permitted to inspect and copy; or,

• Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to AFP's office;

• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to AFP's office;

• Obtain an accounting of disclosures of your health information as required to be maintained by law delivering a request to AFP's office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request: uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to notify family or others responsible for your care of your location, condition, or your death.

• Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to AFP's office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact our Office Manager, in person or in writing, during regular business hours. [S]he will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

AFP is required to:

• Maintain the privacy of you health information as required by law;writing to AFP's office;

• Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

• Abide by the terms of this notice;

• Notify you if we cannot accommodate a requested restriction or request; and,

• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the rights to amend, change, or eliminate, provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Singh at (909)483-7800.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our Office Manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights- US Department of Health and Human Services- 200 Independence Avenue SW- Room 509F, HHH Building Washington DC. 20201

• We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from AFP.

• We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

• Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

• Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location. And about your general condition, or your death

Research.

• We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

• We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organization

• Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Food and Drug Administration (FDA)

• We may disclosed to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
• If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to workers compensation.

Public Health
• As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect
• We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect

Employers
• We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions
• If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcements
• We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight
• Federal law allows us to release your protected health information to appropriate health oversight agencies or health oversight activities.

Judicial/Administrative Proceedings
• We may disclose your protected health information to appropriate health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat
• To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health to the health or safety of a person or the public.

For Specialized Governmental Functions
• We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors
• We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses
• Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website
• If we maintain a website that provides information about our entity, this Notice will be on the website.

Notice of Privacy Practices
For Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

AFP is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services

Examples of Uses of Your Health Information for Treatment Purposes are:
• A nurse obtains treatment information about you and records it in a health record.

• During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/She will share the information with such specialist and obtain his/her input.

Example of Uses of Your Health Information for Payment Purposes:

We submit requests for payments to your health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information t them about you and the care given.

Examples of Uses of Your Health Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Rancho Wellness
YOUR MEDICAL HOME

PATIENT HISTORY FORM

PRINT & COMPLETE: **BRING THIS FORM WITH YOU TO YOUR APPOINTMENT**

Name: Age: Date of Birth:

Who was your previous primary care provider? Dr.

What is the reason for requesting this visit?

PAST MEDICAL HISTORY: Please list any medical conditions from which you have suffered in the past or currently:

PAST HOSPITALIZATIONS: SURGERIES: Please list any surgeries, or hospitalizations, reason & date:

ALLERGIES: *List any allergic reactions or adverse side effects you've had to any drugs or other*:

Drug/Food/Item	Type of Reaction

CURRENT MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION: *List all over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc.*

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS: *List all.*

Herbal preparation	Dose	How often taken

FOR WOMEN ONLY:

Are you using any hormone based birth control?

When was your last menstrual period?	
Number of Pregnancies:	
Number of Births:	

Rancho Wellness
YOUR MEDICAL HOME

Patient History Form

TELL US ABOUT YOURSELF:

Home situation: ○ Single ○ Married;How Long _____ Divorced? How Long _____ Widowed ? How Long _____

Domestic partnership? How Long _____

Employment Status: ○ full-time ○ part-time ○ retired ○ disabled ○ homemaker

Occupation: _____

Habits:

Do you smoke? ○ Yes ○ No If yes, how many packs per day? _____ If you have quit, how long ago? _____

Do you use alcohol? ○ Yes ○ No If yes, how often do you drink? _____ If you have quit, how long ago? _____

Do family or friends worry about your alcohol intake? ○ Yes ○ No

Do you exercise regularly? ○ Yes ○ No

How often? _____ /week What activity? _____ Minutes per session _____

Number of times you eat "fast food" per week? _____

Do you/have you used illicit drugs? ○ Yes ○ No Do you have smoke detectors? ○ Yes ○ No Do you where a helmet when riding a bike or motorcycle? ○ Yes ○ No Do you use seatbelts? ○ Yes ○ No

Transfusions: Have you ever received a blood transfusion? ○ Yes ○ No _____
When?

Immunizations: if YES, give approximate year given

Pneumococcal ○ Yes ○ No H. influenza ○ Yes ○ No Hepatitis B (series of 3) ○ Yes ○ No Tetanus booster ○ Yes ○ No

FAMILY HISTORY: (Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives)

	Maternal Grandparent	Paternal Grandparent	Father	Mother	Brother	Sister	Son	Dtr	Other
Colon or rectal cancer									
Breast or other cancer									
Stroke/Heart Attack before age 65									
Diabetes									
High blood pressure									
High cholesterol									
Alzheimer's Disease									
Alcohol/drug abuse									
Depression									
Bipolar Disorder									
Genetic disorder									
Other (Prostate ca, Ovarian Ca, Melanoma, Bleeding problems, Bloodclots)									

Age of Parents: Mother ____ ○ **Alive** ○ **Deceased** Father _____ ○ Alive ○ Deceased

Number & Age of Children: _____ Healthy ○ Yes ○ No

☐ Are you experiencing an unusually stressful situation? Explain _____

☐ Are there any specific personal issues you would like to bring up at the time of your visit?

Explain: _____

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Patient History Form
SYMPTOM REVIEW

General

- change in weight: ___ lbs during last 6 months
- poor sleep
- fevers
- feeling depressed
- feeling forgetful
- night sweats or chills

Head, Eyes, ears, nose, throat

- headaches or migraines light
- heatedness or dizziness
- bleeding gums
- blurred vision
- other change in vision
- dry eyes
- history of glaucoma or
- cataracts loss of hearing
- ringing in ears
- sinus problems
- hoarseness or voice
- changes dentures: type _____

Cardiovascular

- chest pain
- palpitations or rapid heart beat
- history of angina or heart attack
- history of high blood pressure
- history of irregular beat or murmur
- history of poor circulation
- Date/Result of last EKG _____
- Result of any other cardiac tests _____

Pulmonary/lungs

- shortness of breath
- difficulty breathing
- difficulty breathing lying
- down persistent cough
- sputum
- coughing up blood
- history of asthma or wheezing

Gastrointestinal

- poor appetite
- abdominal pain or
- cramps bloating after
- meals indigestion
- difficulty swallowing
- diarrhea
- constipation
- recent change in bowel habits
- nausea or vomiting
- vomiting blood
- rectal bleeding or blood in stools
- history of jaundice, liver disease or abnormal liver
- tests history of hemorrhoids
- history of colitis
- history of Hepatitis
- Date & result of last colonoscopy _____

Genitourinary

- frequent urination inability
- to hold urine hesitancy
- during urination
- burning or painful urination
- blood in urine
- urinating at night
- Hx of recurrent urinary tract infections
- Hx of kidney stones
- Hx of STDs (eg: Syphilis, Gonorrhea, Herpes, light headedness or dizziness HIV)

Muscle/joint/bone

- swelling of ankles or legs
- muscle aches, pains, or weakness
- joint aches pains or swelling
- Hx of chronic fatigue or tiredness
- Hx of osteoporosis
- Have you ever fallen in last 2 years

Neu rolog ic/Psych iatric

- history of stroke
- blackouts or loss of consciousness
- numbness or tingling in fingers OR hands, OR
- feet leg cramps when walking
- leg cramps or movement at night
- Hx of seizures
- Do you ever feel depressed or anxious or out of control
- History of suicide attempt

Skin

- Itching: where _____
- easy bruising
- new or change in moles
- eczema
- rashes
- lumps or bumps

Endocrine

- history of diabetes
- history of thyroid disease
- change in tolerance to hot or cold weather
- excessive thirst
- excessive urination

Women only

- History of abnormal Pap smear
- History of bleeding between
- periods vaginal discharge
- breast discharge or lumps
- date of last mammogrann _____
- date of last pap smear _____

Men only

- penile discharge
- impotence
- date of last PSA
- date of last prostate exam

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE (3 pages) TO YOUR APPOINTMENT

Rancho Wellness
YOUR MEDICAL HOME

RANCHO WELLNESS FINANCIAL POLICY

We would like to thank you for choosing Rancho Wellness as your primary care provider. We are committed to providing you quality and efficient health care with a smile. In an effort to provide you with the best possible experience during your office visit, we have developed this policy which details our financial requirements to help you understand your responsibilities as a patient.

Knowing your insurance benefits, including co-pays, co-insurances and yearly deductibles, is your responsibility and these are to be paid at time of visit. If you have a yearly deductible that has not been met, a credit card will be kept on file securely, and a deposit towards that visit will be collected at the time of visit. If there is a remainder balance for your visit, once we receive the explanation of benefits, the credit card on file will be charged automatically **ONLY AFTER** 45 days from the time a statement is sent to you and we have not received payment. If for some reason, your insurance pays 100% of the claim, you will have a credit on your account that can be used for future visits. **Initials _____**

All co-payments are due at time of visit. **NO EXCEPTIONS!** We do not except checks. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you. **Initials _____**

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

CANCELLATION/NO-SHOW POLICY:

We understand that there may be times when you miss an appointment due to emergencies. We **URGE** you to call **24 hours** prior to cancelling your appointment. Failure to do so may result in a charge of **$35.00.** If you "no show" for two consecutive appointments or cancel for a total of four appointments without notification, you **WILL** be discharged from care. **Initials _____**

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I, _____, certify that I (or my dependant) have insurance with _____.
I assign directly to Rancho Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for **ALL** charges whether or not paid by any insurance and/or any charges incurred during collection action. I herby authorize Rancho Wellness to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations.

Patient/Guarantor Signature _____ Date _____

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines: YES/NO

_____ _____

Signature of patient or responsible party Date

8231 Rochester Ave, Rancho Cucamonga, CA 91730

Phone: (909)483-7800 . Fax: (909)483-0760

525 N. 13th Ave, Suite A, Upland CA 91786

Phone: (909)982-5111 . Fax: (909)982-9985

Rancho Wellness
YOUR MEDICAL HOME

ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES

_____ _____

Name of Patient (Please Print) Date of Birth

I hereby Acknowledge that I received Rancho Wellness' Notice of Privacy Acts.

_____ _____

Signature of Patient or Patient Representative Date

DOCUMENTATION OF GOOD FAITH EFFORTS

The patient presented to the office on _____ (date) and was provided with a copy of the Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of receipt of the Notice. However, such acknowledgement was not obtained because:

- o Patient refused to sign
- o Patient was unable to sign or initial because:

  _____

- o The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- o Other reason:

  _____

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Rancho Wellness
YOUR MEDICAL HOME

PATIENT PORTAL

Our offices strive to provide you the best quality care. When you come in for a visit, we wish to provide you with our undivided attention. During office hours, our providers are in the midst of seeing patients, where communication is vital to a patient-provider relationship. When calls are made into the office, messages are taken and then handled via our staff or the providers. Often at the end of a busy day we may have twenty or more messages awaiting us. Most messages are simple and can be handled immediately; others are more detailed and require a bit more time. If you factor in the difficulty of returning calls and the inability to get in touch with the patient, this "phone tag" system can greatly complicate matters.

In order to make communication easier and more effective, we have installed a **PATIENT PORTAL, A WEB BASED COMMUNICATION SYSTEM.** Through the portal, and email system, we can document and exchange messages, offer refill requests, appointment scheduling, and access to your lab results. We will require that everyone register for this portal. Communication via the portal will get priority and most times can be handled within the same day or next day. The web portal is to be used for non-emergent matters. Dr. Singh has the ability to deactivate any patient portal account for any reason at his discretion.

I have read the above and consent to use of the portal.

_____ _____

Signature Email

SMS TEXT MESSAGING

I **DO** give my written consent for **Rancho Wellness** to text me on my cell phone regarding appointment reminders, test results or any misc communication.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

I **DO NOT** give my written consent for **Rancho Wellness** to text me on my cell phone regarding appointment reminders, test results or any misc communication.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date

Rancho Wellness
YOUR MEDICAL HOME

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health", we ask you to help us in the following ways:

Schedule Visits With My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended screenings (mammogram, immunizations, pap smears, colonoscopy, etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time, gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear Results Of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *NOT* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that NOT following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide NOT to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, **at any time,** to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health condition, please ask.

_____ _____ _____

Patient signature Date Physician Signature

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CREDIT CARD POLICY

Rancho Wellness will begin placing patient credit cards on file. TransFirst will be the credit card transaction company that we will be utilizing. TransFirst stores your information on a separate site and enables us to run credit card transactions within our computer system. Office personnel will not have access to your card and only the last four digits of your card will be viewable in our system. TransFirst is certified as a Level One Service Provider with the Payment Card Industry (PCI) Data Security Standard, as well as the VISA Cardholder Information Security Program (CISP). They are audited and scanned for PCI compliance and is regularly scanned for vulnerabilities by ScanAlertT and is a member if their HACKER SAFE program.

All patients, New and Existing, WILL be required to have a credit card on file. We appreciate your cooperation and assistance in this process.

CREDIT CARDS ON FILE WILL BE USED FOR:

COPAYS-When you are in the office, you will need to present your credit card, even if the card is on file. For someone other than the financially responsible party bringing your child to an appointment, we will run you card on file for the copay owed.

BALANCES- If your insurance carrier assigns any additional patient responsibility amounts; we will run the credit card of file for this amount if payment is not received within 45 days of statement being sent to responsible party.

For all patients responsibility amounts by insurance, our office reviews these amounts to ensure your claim has been properly adjudicated. If what is adjudicated by the insurance company does not match your benefits we verified with insurance at the time of service, we will contact you and your insurance carrier. Members typically receive their explanation of benefits (EOB) prior to the provider, so if you disagree with the patient responsibility amount owed, it is YOUR responsibility to contact your insurance carrier immediately.

If your credit card is mistakenly run, we will immediately issue you a refund back on the credit card you have on file.

During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.

CREDIT CARD ON FILE AUTHORIZATION

I understand that my insurance policy includes a deductible and/or co-insurance that apply to my medical visit today and there may be a post patient responsibility. I agree to place my credit card on file to be run by Rancho Wellness once the claim has been adjudicated for any additional patient responsibility amounts that has not been credited to my account.

On the day we receive your explanation of benefits from your insurance and there is an outstanding amount owed by you, as the patient, we will send out a statement to you. If within 45 days of sending out the statement, the balance has not been paid, we will automatically run the credit card that we have on file. A receipt will be emailed to the email we have on file for you.

I, _____, authorize Rancho Wellness to run my credit card for the purpose(s) stated above.

Name on card _____ Date _____

Signature of authorizing person _____

Email address _____