CONFIDENTIAL PATIENT REGISTRATION FORM

*** **MUST** BE FILLED OUT SO THAT WE CAN BILL YOUR INSURANCE EFFECTIVELY ***

PATIENT INFORMATION/DEMOGRAPHICS

first

middle

last

SS#_____-_____-_____

Date of Birth_____ Age:_____

Tel: HOME _____ CELL _____

Sex: M F Marital Status: ☐ S ☐ M ☐ W ☐ D

Address:_____City:_____State:_____Zip:_____

(P.O. Boxes are not acceptable)

Employer Name:_____Employer Tel:_____

Emergency Contact: _____ Relationship:_____ Tel:_____

INSURED / RESPONSIBLE PARTY INFORMATION (THIS SECTION MUST BE COMPLETED)

This visit is related to: (please check all appropriate boxes)

☐ **INSURANCE** ☐ **CASH**

PRIMARY INSURANCE:_____ID #:_____Group #:_____

AUTHORIZATION FROM ADJUSTOR/ATTORNEY MUST BE OBTAINED PRIOR TO DATE OF SERVICE FOR THE FOLLOWING
☐ **WORKER'S COMP** ☐ **AUTO INJURY** ☐ **PERSONAL INJURY (LIEN MUST BE SIGNED BY ATTORNEY & PATIENT)**

Date of Injury:_____ Carrier:_____

Adjuster/Attorney Name:_____Tel:_____

☐ **SAME AS ABOVE**
Name of Insured:_____Relationship to Patient:_____Tel:_____

Home Address:_____City:_____Zip:_____

Employer Name:_____Employer Tel:_____

Insured SS #:_____Date of Birth_____

SECONDARY INSURANCE:_____ID #:_____Group #:_____
(Note: Secondary Insurance claims will only be submitted if this section is accurate and completed on or prior to the date of service)

☐ **SAME AS ABOVE**
Name of Insured:_____Relationship to Patient:_____Tel:_____

Home Address:_____City:_____Zip:_____

Employer Name:_____Employer Tel:_____

Insured SS #:_____Date of Birth_____

I UNDERSTAND THAT ANY FALSE OR OMITTED INFORMATION IN THE GREY COLORED SECTIONS MAY RESULT IN A CLAIM DENIAL AND THE FULL BALANCE WILL BECOME MY RESPONSIBLILTY.

Date	Patient/Parent/Guardian/Conservator/Agent	If other than patient, indicate relationship

CONDITIONS OF ADMISSION:

OAK TREE ASC LLC; PASADENA MEDICAL IMAGING LLC; OAK TREE MEDICAL CORPORATION; R ROBERT WYCOFF MD INC

ARBITRATION AGREEMENT: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this agreement were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Such arbitration shall be in accordance with the current Medical Arbitration Rules of the California Medical Association. This arbitration agreement shall apply to any legal claim or civil action in connection with this outpatient service or treatment plan of services, against the OAK TREE ASC LLC, OAK TREE MEDICAL CORPORATION, PASADENA MEDICAL IMAGING LLC, R ROBERT WYCOFF MD INC (collectively "OAK TREE") or its employees and any doctor of medicine who has agreed, at the time of your procedure, as evidenced by a written agreement in the physician's medical staff file, to be bound by this provision, unless patient or undersigned initials below or unless rescinded by written notice within 30 days of signature. Any agreement to arbitrate shall not be a precondition to the furnishing of services under this agreement.

_____ IF THE PATIENT OR UNDERSIGNED DOES NOT AGREE TO ARBITRATION THEN HE/SHE WILL INITIAL HERE.

CONSENT TO MEDICAL PROCEDURES: The undersigned consents to the procedures which may be performed on an outpatient basis rendered to the patient under the general and special instructions of the patient's physician.

LEGAL RELATIONSHIP BETWEEN PATIENT AND CENTER: The patient is under the care and supervision of an attending physician or radiologist, and it is the responsibility of OAK TREE and its nursing staff to carry out the instructions of such physician or radiologist. Any questions concerning the nature or results of any examination or treatment should be directed to the patient's attending physician or radiologist and not to OAK TREE employees.

RELEASE OF INFORMATION: OAK TREE shall not release information, other than basic information concerning the patient, without the patient's consent and his/her written authorization to release such information, except in those circumstances where OAK TREE is permitted or required by law.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, OAK TREE may disclose portions of the patient's record, including his/her medical record, to any person or entity which is or may be liable for all or any portion of OAK TREE's charges, including but not limited to government agencies (e.g. Medicare), insurance companies, health care service plans, or workers' compensation carriers. State laws require us to report certain cases of infectious diseases and cancer to governmental health agencies.

The HIPAA Notice of Privacy Practices for OAK TREE is available upon request.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account to OAK TREE in accordance with the regular rates and terms of OAK TREE. The undersigned assumes all financial responsibility for any post-operative hospitalization. The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to OAK TREE of any insurance or other applicable (e.g. Medicare, 3rd party liability) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, including emergency services if rendered, at a rate not to exceed OAK TREE's regular charges. OAK TREE bills an insurance or 3rd party carrier on the patient's behalf. However, if payment for services rendered is not received in a timely manner, he/she will be responsible for the account balance.

DEMOGRAPHIC INFORMANTION

I understand that it is my responsibility to supply correct demographic information, including primary/secondary insurance and any other pertinent information needed to properly bill my insurance. Incorrect or omitted information may result in a denial. *If this information is not supplied **at the time of service**, OAK TREE does not retroactively bill claims; therefore, I will be responsible for my account balance.*

PROCEDURE CANCELLATION

I understand that once admitted to the facility, if a procedure is cancelled prior to commencement, I will be responsible for a $250.00 charge. If the procedure is cancelled during the exam/intervention, I will be responsible for a minimum $650.00 charge.

COLLECTIONS POLICY

Patient accounts are sent to a collection company if patient responsibility payments are not made within ninety (90) days of insurance coverage determination. I agree to pay interest at the rate of 18% annually on all past due balances exceeding ninety (90) days from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance. If my account is sent to a collection company, an additional fee of 25% (but no less than $40.00) will be added to the principal amount of my account.

INSURANCE BILLING / PAYMENTS

Patients are responsible for all balances owed on their accounts including deductibles, co-payments and co-insurances. Furthermore if a claim is denied because "services not authorized" or deemed "not medically necessary" or "bundled" or for any reason, I will become responsible for my account balance. OAK TREE makes no assurance of being a participating provider or that my insurance will pay the claim(s) submitted.

PRIOR AUTHORIZATION / PRE-CERTIFICATION

OAK TREE performs basic eligibility and prior authorization services for its own benefit. No assurance is made that my procedure has been authorized or that you are eligible for services. I understand that it is my responsibility to obtain or ensure that my primary care physician or referring physician's office has obtained any pre-certification or authorization necessary and/or required by my health plan prior to any service or procedure being performed.

OUT-OF-NETWORK PAYMENTS

OAK TREE may elect, at its own discretion, to bill a claim out-of-network (OON). If my insurance sends me an OON payment directly, I agree to remit payment to OAK TREE immediately. If not, I will be responsible for the full billed charges on my account.

MEDICARE

OAK TREE is a Medicare provider. Patients are responsible for meeting their annual deductible and paying the 20% co-payment for each date of service. OAK TREE will bill a secondary/supplemental carrier on my behalf; however, I will be billed any deductible and/or coinsurance that is not covered, allowed or otherwise paid by my secondary insurance. ***Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers. If we are not informed, you are responsible for the balance of your account.***

WORKERS COMP / AUTO ACCIDENTS / LIENS

I understand that if my injury is related to an auto accident or other 3rd party liability, my private health plan should not be billed. If OAK TREE is not properly informed prior to the procedure/exam, I will become responsible for full account balance. I also understand that if my private health plan denies any claims submitted by this office, requests a refund or recovers any payments made to this office, I will be expected to pay my balance(s) in full immediately.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms. I agree to accept all financial responsibility for services rendered to the patient and to accept the terms of the provisions enumerated above.

_____	_____	_____
Date	*Patient/Parent/Guardian/Conservator/Agent/ Financially Responsible Party*	*If other than patient, indicate relationship*

_____	_____
Time	*Witness*