

# MODESTO ARTS MEDICAL GROUP

Please Print

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_

Social Security \_\_\_\_\_ Driver's License # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Do you have an e-mail address? \_\_\_\_\_

Do you have any drug allergies? \_\_\_\_\_

Nearest Relative (not living with you) \_\_\_\_\_ Phone # \_\_\_\_\_

Name of friend in the area \_\_\_\_\_ Phone # \_\_\_\_\_

Did someone refer you to us? \_\_\_\_\_

Who is your Primary Care Doctor, or Family Doctor? \_\_\_\_\_

If applicable, date of last pap and where \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

## SPOUSE/PARTNER

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Security # \_\_\_\_\_

## INSURANCE INFORMATION.

Insurance #1 \_\_\_\_\_ Group Number \_\_\_\_\_

Address and Phone \_\_\_\_\_ ID Number \_\_\_\_\_

Insurance #2 \_\_\_\_\_ Group Number \_\_\_\_\_

Address and Phone \_\_\_\_\_ ID Number \_\_\_\_\_

## IF YOU ARE A STUDENT OR MINOR COVERED UNDER PARENT'S INSURANCE, PLEASE COMPLETE THIS SECTION....

Father \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Father's Employer and Occupation \_\_\_\_\_

Mother \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Mother's Employer and Occupation \_\_\_\_\_

As a patient, or as legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to Modesto Arts Medical Group. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

I state that this information is correct to my knowledge. I have read and agree to comply with the office policy stated in the patient information sheet.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

# MODESTO ARTS MEDICAL GROUP, INC.

## FINANCIAL POLICY

### *CASH PATIENTS*

Payment in full is expected at time of service. We do accept Visa and MasterCard as well as cash and checks.

### *HMO/PPO MEMBERS*

Co-payments are due and payable prior to your visit, according to the contract you have with your insurance company. It is also your responsibility to be aware of which laboratory and radiology facility your HMO or PPO is contracted with, so services provided are billed correctly.

Effective January 1, 1999 a new California State Law went into effect, granting women access to their OB/GYN within their network panel of physicians, without a referral from their Primary Care Doctor as long as services are related to obstetrics or gynecology.

### *PRIVATE INSURANCE/MEDICARE*

When provided with your insurance information, we will file a claim with them as a courtesy. If your insurance company has not paid within 90 days, the balance becomes your responsibility. You are also responsible for any co-payment and or deductibles that may not have been met yet.

### *FAILED APPOINTMENTS*

There will be a \$25 fee charged to anyone who schedules an appointment and fails to keep it. Please let us know if you are unable to come in, preferable 24 hours in advance. We do understand that sometimes situations come up at the last minute, but please take the time to call us and reschedule.

SHOULD THIS ACCOUNT BECOME PAST DUE, I AGREE TO PAY ANY FINANCE CHARGE OR LEGAL FEES NECESSARY TO COLLECT ON THIS ACCOUNT.

BY SIGNING THIS YOU ARE AUTHORIZING BENEFITS TO BE PAID TO THE PROVIDER, AND ACKNOWLEDGING YOUR UNDERSTANDING OF OUR FINANCIAL POLICY.

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PATIENT OR RESPONSIBLE PARTY SIGNATURE

DATE

Delmar R. Tonge, M.D.  
John C. Pfeffer, M.D.  
Randy D. Winter, M.D.  
Sean B. Clare, M.D.

MODESTO  
ARTS MEDICAL  
GROUP, INC.

1400 Florida Avenue  
Suite 207  
Modesto, California 95350  
Tel. (209) 522-1027  
FAX (209) 522-7956

*Obstetrics, Gynecology, Infertility*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
TO OTHER INDIVIDUALS

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Social Security #: \_\_\_\_\_

I hereby authorize: MODESTO ARTS MEDICAL GROUP  
To release (either verbally or printed) my Protected Health Information to the  
Following persons:

\_\_\_\_\_  
Name of person Relationship to patient

\_\_\_\_\_  
Name of person Relationship to patient

\_\_\_\_\_  
Name of person Relationship to patient

\_\_\_\_\_  
Name of person Relationship to patient

This authorization shall remain in effect until \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature Date signed