

RANCHO FAMILY
MEDICAL GROUP
Physician-Patient Arbitration Agreement

1. **Agreement to Arbitrate.** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract 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 a 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.

2. **All Claims Must be Arbitrated.** It is also understood and agreed that any dispute that does not relate to medical malpractice, including, but not limited to, a dispute as to whether or not a particular dispute is subject to arbitration, the handling or other disposition of patient information and records, any claim that this arbitration agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this arbitration agreement bind all parties as past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. The filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

3. **Procedures and Applicable Law.** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including attorney fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to healthcare providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrator a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05; however, depositions may be taken without prior approval of the arbitrator.

4. **General Provision.** All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrator shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

5. **Revocation.** This arbitration agreement may be revoked by written notice delivered to the health care provider within thirty (30) days of signature and, if not revoked, will govern all medical services received by the patient and all other disputes between parties.

6. **Retroactive Effect.** This arbitration agreement is effective as of the date of first medical services.

7. **Miscellaneous.** This Agreement supersedes all previous agreements, whether written or oral, express or implied, relating to the above subject matter, and shall not be changed or subject to change orally. If any provision of this arbitration agreement is held invalid or unenforceable, whether by arbitration or a court of competent jurisdiction, the remaining provisions shall remain in

I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Health Care Provider:
Rancho Family Medical Group, Inc.

Sign: _____

Date: _____

Patient Name: _____

Sign: _____

Date: _____

(Parent/Guardian/Representative of Patient):

Print: _____

Relationship: _____

Sign: _____

Date: _____



NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.
To check up on a license or to file a complaint go to the website: www.mbc.ca.gov
or email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

Notice of Zero Tolerance

Rancho Family Medical Group has zero-tolerance for physical and/or verbal threats towards staff members, other patients guests.

RANCHO FAMILY
MEDICAL GROUP
WELCOME LETTER

Dear Patient,

Welcome to Rancho Family Medical Group. 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 YOUR PROVIDER 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 that I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). **These health screenings are tests that can help detect lifethreatening 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 THE 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 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 test 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 health care. 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

Notice of Privacy Practices



Privacy Officer: Vicki Johnson, DrPH, CHC,
CHPC 28780 Single Oak Drive, Suite 280
Temecula, CA 92590

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.**

You have a right to...

- Get a copy of your paper or electronic medical record, usually within 30 days of your request. Reasonable fees may be charged.
- Request a correction of your paper or electronic medical record. Please contact our Privacy Officer if you think your record contains an error.
- Request confidential communication. You can specify in writing how you want us to communicate with you and we will honor all reasonable requests.
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.
- Get a list of those with whom we’ve shared your information. You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will list everyone except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months
- Get a copy of this privacy notice. You can have an electronic or paper copy and we will give you a new copy each time there is a significant change to the notice.
- Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the choice....

- In what information we tell, and to which family and friends about your condition As we provide disaster relief, in what information we share about you.
- If you want to be included in a hospital directory.
- If you want to have your information shared as we for market our services, or host fundraisers. Selling your information is ONLY done with your written permission.

Our Permitted Uses and Disclosures

We may use and share your information as we:

- Provide treatment for you, run our organization, and bill for your services. For example, we may share your information when we order lab tests or referrals or prescriptions.
- Verify insurance coverage and to bill for the services we provided to you.
- Help with public health and safety issues. We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone’s health or safety
 - For special government functions such as military, national security, and presidential protective services
 - Do research

- Comply with the law, or respond to lawsuits or legal actions. This means we can share health information about you in response to a court or administrative order, or in response to a subpoena.
 - Respond to organ and tissue donation requests
 - Work with a medical examiner or funeral director
 - Address workers' compensation, law enforcement, and other government requests

Our Prohibited Uses and Disclosures

- **Reproductive Health:** We will not share your reproductive health information without your specific written permission, and in most instances, we will require an attestation form certifying special protections from the person requesting such information.
- **Sensitive Health Information, Substance Abuse and Mental and Behavioral Health Records:** We will not share any of your health information that relates to HIV Status, substance abuse treatment, mental or behavioral health treatment, or genetic information unless required by law, or upon receipt of specific written permission is received from you.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Complaints

If you believe your privacy rights have been violated, you may file a complaint by contacting our compliance hotline.

Website: <https://report.syntrio.com/ranchohealth>

Phone: English speaking USA and Canada: (833) 562-2600 (not available from Mexico)

Phone: Spanish speaking North America: (800) 216-1288

E-mail: reports@lighthouse-services.com (must include company name with report)

Fax alternative for written documents: 215-689-3885 (must include company name with report)

You may also speak with someone from our management team who will connect you with our privacy officer.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1

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877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Patient Rights and Responsibilities

Patient Rights: Rancho Family Medical Group respects the right to treatment and care of all our patients and their families. Those rights include:

Decision Making

- Be informed of your rights before patient care is given or discontinued, whenever possible.
- Receive complete and current information regarding your health status including diagnosis, treatment, risks and benefits of treatment, serious side effects, alternatives to treatment and consequences of not receiving treatment in a way that you can understand.
- Participate in care planning, and treatment decisions, by giving or withholding informed consent, or requesting specific treatment. Participate in managing your pain effectively.
- Have a family member, friend, or other individual present for emotional support during office visits. You will be informed if a restriction or limitation is in place for your health or safety.
- Refuse or discontinue treatment to the extent permitted by law and to be informed of the consequences of such refusal.
- Have information about the outcomes of care, treatment options, services, as well as risks.
- Request a second opinion.
- Request that an in-network healthcare provider deliver services, if available.
- Create an advance directive, which includes your wishes relating to end-of-life decisions, and be informed if these cannot be honored. Be protected and have your rights respected during research, investigation, and clinical trials involving human subjects.
- Consent to records or films made for purposes other than patient care.

Respectful, Safe, and High Quality of Care

- Respectful treatment which recognizes and maintains your dignity, values, beliefs and preferences. Care in a safe setting.
- Be free from mental, physical, sexual and verbal abuse, neglect, and exploitation.

Billing

An itemization of your bill and charges will be provided to you within 7 business days.

Medical Debt:

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable. We remain committed to working with you to resolve any outstanding balance and appreciate your continued trust in our care.

Access to Medical Records

- Review and get a copy of your medical records at any time
- Request an amendment to your medical record

Confidentiality and Privacy

- Personal privacy including the right to be interviewed and examined in surroundings designed to assure reasonable audio and visual privacy. Personal information is being shared only with those who are involved in your health care.
- Confidentiality of your Protected Health Information and access to disclosures of your information.

Grievance Process

- Voice a complaint to your health care providers and office managers without fear of reprisal.
- Grievances are directed to the Compliance Department, who will respond within 7 business days.

Patient Responsibilities

You and your representative(s) have the responsibility to:

- Be involved in your care
- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other health-related matters.
- Report perceived risks in your care and unexpected changes in your condition.
- Understand and follow your treatment plan, ask questions when needed, and accept the risks if you choose not to follow the plan.
- Provide accurate and updated information for insurance and billing.
- Speak up about concerns you may have about the quality of your care and treatment.
- At all times show respect.

Notice of Zero Tolerance

Rancho Family Medical Group has zero-tolerance for physical and/or verbal threats towards staff members, other patients guests.

Notice of Nondiscrimination

Rancho Family Medical Group complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Rancho Family Medical Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Rancho Family Medical Group Provides free language assistance services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Information written in other languages
- Provides free language services (such as qualified interpreters and documents translate to other languages) to people whose primary language is not English.
- If you need these services, contact our main office line at **(951) 252-8650**

If you believe that Rancho Family Medical Group has failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex:

- You can contact our main office and ask to speak to the office manager to report your concerns. • You can also file a grievance with your insurance medical group by phone call, mail, fax or email.
- You can file a report through our compliance hotline.
 - Website: <https://report.syntrio.com/ranchohealth>
 - Phone: English speaking USA and Canada: (833) 562-2600 (not available from Mexico);
 - Spanish speaking North America: (800) 216-1288
 - E-mail: reports@lighthouse-
 - Fax alternative for written documents: 215-689-3885 (must include company name with report)
- You can also file a concern with the U.S Department of Health and Human Services, Office for Civil Rights, electronically
 - through the Office for Civil Rights Complaint Portal <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
 - or by phone at: **1-800-368-1019**
 - Or by mail at: **U.S Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DC xxxxx**

ACKNOWLEDGEMENTS

I have received a copy and have read and understand the Patient Rights and Responsibilities Agreement.

Signature of Patient

Printed Name

Date

I have received a copy of and read and understand the Notice of Privacy Practices.

Signature of Patient

Printed Name

Date

How did you hear about us?

Please let us know which of the following introduced you to Rancho Family Medical Group.
(Check all that apply).

_____ Friends or Family

_____ insurance Company. If Insurance Company, please list name _____

_____ Search Engine (Google, Yahoo, Bing...)

_____ Event in the Community. If so, which event? _____

_____ Facebook

_____ Commercial

_____ Newspaper

_____ Other. Please specify: _____



Communication Preferences and Authorizations

How we protect your privacy

We use high security measures to protect against the loss, misuse and alterations of data used by our system.

Sharing and Usage

We will never share, sell, or rent individual personal information with anyone without your advance permission or unless ordered by court of law. Information submitted to us is only available to employees managing this information for purposes of contacting you or sending you emails based on your request and consent for information and to contracted service providers for purposes of providing services related to our communications with you.

How can you stop receiving emails from us?

Each email sent to you contains an easy, automated way to cease receiving emails from us, or to change your expressed interests. If you wish to do this, simply follow the instructions at the end of any email. If you have received unwanted, unsolicited email sent via system please forward a copy of that email with your comments to support@ranchomed.com for review.

I understand that under the federal Health Insurance Portability and Accountability Act of 1996, this medical office may not release any information to any individual without my express written permission. Therefore, I give permission to Rancho Family Medical Group to release pertinent information on my behalf, in the following ways and to the following person(s), if any:

<p>①</p>	<p>Consent to leave voice message: I understand that as part of my healthcare and treatment, Rancho Family Medical Group may need to reach me by phone. To receive effective care and timely notifications, I authorize Rancho Family Medical Group providers and staff to leave detailed messages regarding lab results, x-ray results, prescriptions and refills, treatment, etc. using a personal telephone number that I have provided to be listed in my medical record.</p> <ul style="list-style-type: none"> • I agree to notify Rancho Family Medical Group as soon as possible, via patient portal, telephone call, or in person if my contact information changes. • I agree that if I have test results that I have not been informed of within 4 business days, I will contact the office at Rancho Family Medical Group to inquire about those results and any follow up instructions. NO NEWS does not always mean GOOD NEWS, and it may simply mean that my provider has not received the results. • I understand that it is my responsibility to follow up with my provider about test results, prescriptions, and referrals.
<p>②</p>	<p>I authorize Rancho Family Medical Group to release my medical information to</p> <p>☐ Myself</p> <p>☐ Myself and the person listed below:</p> <p>Name: _____ DOB: _____</p> <p>Address: _____ DL#: _____</p> <p>City: _____ ST: _____ ZIP: _____</p> <p>Phone _____ email: _____</p>
<p>③</p>	<p>Patient Name: _____ DOB: _____</p> <p>Signature: _____ Date: _____</p>



General Consent for Treatment

1. I voluntarily consent to and authorize the physicians, nurse practitioners, physician assistants, and other licensed or supervised healthcare personnel of Rancho Family Medical Group (“the Practice”) to perform routine primary care evaluations, treatments, and procedures for me. These services may include, but are not limited to:
 - Medical history review and physical examinations
 - Preventive and diagnostic services
 - Laboratory tests and specimen collection
 - Administration of medications and injections
 - Minor office procedures
 - Referrals to specialists or ancillary services when medically indicated
2. I understand that the practice of medicine is not an exact science, and that no guarantees or warranties have been made to me regarding the results of treatment or services.
3. I acknowledge that:
 - The nature and purpose of recommended treatments have been explained to me in terms I understand.
 - I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.
 - I may refuse or withdraw consent for any treatment at any time, except in situations involving medical emergencies or where otherwise permitted by law.

Patient/Representative Name

Relationship to Patient

Signature

Date



FINANCIAL DISCLOSURE STATEMENT AND ASSIGNMENT OF BENEFITS

Thank you for choosing our practice for your healthcare needs. This Financial Disclosure Agreement outlines your financial responsibilities as a patient of our office. Please read it carefully.

Your Rights

- You have the right to receive clear, understandable information about our billing policies and charges for services provided.
- You have the right to know how your insurance will be billed based on the information you provide.
- You have the right to request an explanation of your charges and receive an itemized statement upon request.
- You have the right to discuss payment options if you are unable to pay your balance in full.

Your Responsibilities

- You are responsible for providing accurate and current insurance, demographic, and contact information at each visit.
- You are responsible for understanding your insurance benefits, including copayments, deductibles, coinsurance, and coverage limitations.
- You are responsible for payment of all copays at the time of service.
- You are responsible for any charges not covered by your insurance, including services applied to your deductible, denied claims, or non-covered services.
- You are responsible for notifying our office of any changes to your insurance coverage as soon as possible to avoid claim delays or denials.

Additional Billing Information

- Services provided will be billed to your insurance as a courtesy; however, you are ultimately responsible for any balance not paid by your insurance company.
- Insurance coverage varies by plan. Some services may not be considered medically necessary or may not be covered under your specific benefits.
- Preventive visits (such as annual wellness exams) may include both preventive and problem-focused services, which may result in additional charges depending on services addressed during the visit.
- Certain services, including completion of forms, administrative requests, or non-covered services, may be billed directly to the patient.
- If your insurance denies a claim, you may be responsible for the remaining balance.

Self-Pay Services

- If you do not have active insurance coverage, choose not to use insurance, or receive services not covered by your plan, you will be considered a self-pay patient.
- Self-pay charges are due at the time of service unless prior arrangements have been made with our billing office.

- We can provide an estimate of charges for services upon request; however, final charges may vary depending on services performed during the visit.
- Self-pay rates may differ from insurance contracted rates and are established based on standard practice fees.

Billing Statements and Payment

If a balance remains after insurance processing, you will receive a billing statement. Payment is due upon receipt unless prior payment arrangements have been made with our billing office.

Questions About Your Bill

We encourage you to contact our billing team with any questions or concerns. We are committed to helping you understand your financial responsibility and available payment options.

Effective January 1, 2025,

California law (Senate Bill 1061) prohibits healthcare providers and debt collectors from reporting medical debt to consumer credit reporting agencies. This means that unpaid medical bills will no longer appear on your credit report or impact your credit score. In Compliance with this law, our office will no longer furnish information about medical debt to credit reporting agencies. We remain committed to working with you to resolve any outstanding balance and appreciate your continued trust in our care.

ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits be made directly to Rancho Family Medical Group. I understand that I am financially responsible to Rancho Family Medical Group for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including reasonable attorney's fees. This authorization will remain in effect until revoked in writing by the undersigned. I certify that the above is correct.

Patient/Representative Name

Relationship to Patient

Signature

Date

PATIENT REGISTRATION FORM

PATIENT INFORMATION										
PATIENT'S LEGAL LAST NAME		LEGAL FIRST		MI	MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED		DATE OF BIRTH	AGE	SEX	
ADDRESS		APT #	CITY	STATE	ZIP	HOME PHONE NO.	SOCIAL SECURITY NO.			
E-MAIL ADDRESS						CELL PHONE NO.				
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)						OTHER NAMES USED				
* ETHNIC ORIGIN ☐ AFRICAN –AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ NATIVE AMERICAN ☐ OTHER _____										
* COUNTRY OF BIRTH					* PRIMARY LANGUAGE					
PERSON RESPONSIBLE FOR PATIENT'S EXPENSE					EMPLOYER					
NAME LAST		FIRST		MI	NAME					
ADDRESS			DATE OF BIRTH		ADDRESS					
CITY		STATE	ZIP		CITY		STATE	ZIP		
RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.		PHONE NO.		PHONE NO.		OCCUPATION		
SPOUSE OF PERSON RESPONSIBLE					SPOUSE'S EMPLOYER					
NAME LAST		FIRST		MI	NAME					
ADDRESS			DATE OF BIRTH		ADDRESS					
CITY		STATE	ZIP		CITY		STATE	ZIP		
RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.		PHONE NO.		PHONE NO.		OCCUPATION		
LOCAL EMERGENCY CONTACT					SECONDARY EMERGENCY CONTACT					
NAME			RELATIONSHIP TO PATIENT		NAME			RELATIONSHIP TO PATIENT		
CITY		STATE	PHONE NO.		CITY		STATE	PHONE NO.		
INSURANCE INFORMATION										
PRIMARY	Subscriber's Name		Subscriber's SSN		Subscriber's DOB		Subscriber's Emp.		Relationship to Pt.	
SECONDARY	Subscriber's Name		Subscriber's SSN		Subscriber's DOB		Subscriber's Emp.		Relationship to Pt.	
FOR OFFICE USE ONLY										
Guarantor #			Patient #				Location #			

Signature _____

Date _____