ORANGE COUNTY WOUND and HYPERBARIC

BAROMEDICAL PHYSICIANS ASSOCIATES MEDICAL GROUP

720 N. Tustin Ave., Ste 100
Santa Ana, CA 92705
Phone: (714) 973-8777 Fax: (714) 973-8778

INSURANCE CARDS: Please provide a current copy of your insurance cards, DL or photo ID

FINANCIAL RESPONSIBILITY:
It is my responsibility to keep Orange County Wound and Hyperbaric,
a.k.a. Baromedical Physicians Associates Medical Group, aware of any changes or modifications to my insurance coverage. I understand and agree that (regardless of insurance status), I am ultimately responsible for the full balance of my account for the professional services I receive. We also require that charges for co-payments, deductibles, and supplies be paid for on the day of service. You will be billed directly when any part of the payment for services you have received is denied or not received within 120 days after the bill is submitted to your insurance company. **_______initial**

CONSENT TO TREATMENT: This consent authorizes the physician or medical associate to administer, prescribe medication, provide medical treatment, perform surgical procedures, and document the treatment with photographs, videos, as needed**.** **_______initial**

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Orange County Wound and Hyperbaric/Baromedical Physician Associates Medical Group, Inc. the insurance and/or Medicare benefits to which I am entitled. I understand that I am financially responsible for charges not covered by this assignment**.**
_______initial

MISSED AND CANCELLED APPOINTMENTS: I understand and agree that I may be charged ($25) for missed appointments or appointments cancelled within less than 24 hours' notice to our office. **_______initial**

FORMS: There will be an additional $25 charge for any form(s) (Handicap Placard, Disability, DMV, etc.) filled out by the MD/PA/NP. _______initial

SUPPLIES: We may recommend supplies that may be helpful to improve your condition. When these supplies are covered by your insurance, we will submit the necessary paperwork. However, in instances when your insurance will not cover supplies, our office can provide the supplies to you at a reasonable cost and/or provide you information on where to purchase these supplies. The choice to purchase these items is yours. **_______initial**

INSUFFICIENT FUNDS FEE: There will be an additional $25 fee charged for any checks that are returned to OCWH due to insufficient funds. _______initial

Patient Full Name ____________________________ Birth Date: ___________________

SIGNATURE: ____________________________ DATE: ______________________

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PATIENT INFORMATION

LAST NAME: ______________________FIRST NAME: ________________MIDDLE:___________

ADDRESS: ____ Apt #: ________CITY: ______________

STATE: _______ ZIP CODE: ___________ Social Security #__________________________

HOME PHONE: (___) ______________ CELL PHONE: (___)_____________________

EMAIL_________________________________

Language: __________________ Ethnicity (optional):______________________

BIRTHDATE: ____/___/____ GENDER: M / F /OTHER MARITAL STATUS: S M D W

SPOUSE:_________________________________PHONE #__________________________

PRIMARY CARE PHYSICIAN NAME: __________________________________

PHONE #: (____) ______________________ FAX # (___)__________________

REFERRING PHYSICIAN: (if different) _________________________

PHONE #:(___)_______________

REFERRING HOME HEALTH AGENCY (if any): _________________________

PHONE: (___)___________________FAX: (___)______________

EMERGENCY CONTACT

LAST NAME: _________________________ FIRST NAME: ___________________

HOME PHONE/WORK: (___)_____________ CELL PHONE: (___)_____________

RELATIONSHIP TO PATIENT: _______________________

In accordance with HIPAA, (HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT), we are required to institute specific confidentiality safeguards re: your personal medical health information.
By signing below, you are authorizing and acknowledging that the person listed above may be provided PHI.

SIGNATURE_____________________________________ DATE_______________________

ORANGE COUNTY WOUND and HYPERBARIC

Patient Name: ________________________________ **Date:**____________________________

Allergies (medication/food/other):____
Pharmacy Name:__________________
Phone #____________________**City:**__________________

MEDICATION LIST

MEDICATION	DOSE	FREQUENCY
MEDICAL PROBLEM LIST (Past Surgeries/diagnoses, etc..)		