Patient Last Name _____ First Name _____ MI _____ Date: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Marital Status _____

Sex: M or F Date of Birth _____ E-mail _____

Social Security Number _____ REFERRING DR. _____

Emergency Contact _____ Phone Number _____

Emergency Contact Relationship _____

Race: *Please select one*

___ American Indian or Alaska Native ___ White ___ Asian

___ Black or African American ___ Hispanic ___ Native Hawaiian

___ Other Race ___ Refuse to Report

Ethnicity: *Please select one*

___Hispanic ___ *Non*-Hispanic ___ *Refuse* to Report

Language: _____

Insurance: * ***If you are covered by a spouse or parent you must fill out below***

Spouse/Parent Name _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse or Parents Date of Birth _____

Pharmacy: _____ Address: _____ Phone: _____

Consent for RX Hub Inquiry

I hereby provide consent for the Physician's Practice to obtain my Rx history using the SureScripts-Rx Hub Network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx has certified Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system to system communications.

Signed_____ Date_____

Consent for Treatment

Signed_____ Date: _____

HIPAA Notice of Patient Privacy Practices

I acknowledge the receipt of Physician's Practice privacy notice. I may request a copy of the privacy practice notice at any time.

Signed_____Date:_____

Consent for release of Information

I the undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf on myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby provide consent for the Physician's Practice to release medical data to other organizations to adjudicate a claim.

Signed_____Date_____

I the undersigned authorize the release of medical information from my file to (this is for family or friends):

1. Name_____Relationship_____Phone Number_____

2. Name_____Relationship_____Phone Number_____

3. Name_____Relationship_____Phone Number_____

Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD

FINANCIAL POLICY

Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement form from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. RETURNED CHECKS will incur a $35.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $35 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $35

service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Santa Clara County.

4. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. BILLING OFFICE: If you have questions in regards to any of your billing statements, our accounts receivable staff is available to assist you. CALL 408-560-2714.

6. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD for charges not covered by the assignment of insurance benefits.

7. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD. I authorize Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. SELF PAY PATIENTS OR PROMPT PAY PATIENTS WHO ARE INSURED: A 20% prompt pay discount is applied to all full pay payments received at the time of service whether or not you carry insurance. This means anyone willing to/or needing to pay in full at the time of service will receive a 20% discount off of the evaluation and management service codes only. Charges for supplies, tests, immunizations, medications, or procedures are not discounted. Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD do not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service. By signing below I state that I am not eligible for Medicaid and will never ask this office to bill them.

9. RELEASE OF INFORMATION: I hereby authorize and direct Gopi Ayer MD, Mandeep Ayer MD, Jane Chien MD to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all the information needed to substantiate claim and payment.

10. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

11. NON FACE TO FACE SERVICES: Patient authorizes physician to bill insurance, such as Medicare, for non-face to face services, such as consultations with other physicians and electronic/telephone communication with patients, as allowed by Medicare and other insurances.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____
Please print the name of the patient