Dr. Lindsay J. Fox, M.D., General Surgeon 830 Pine St, Mount Shasta, CA 96067 - Ph (530) 918-9331 - Fax (530) 918-9323

New Patient Registration

Welcome to our office! We are so excited to meet you and to take care of you today!

Your name:_____ Date of Birth:_____

Preferred Name:_____ Social Security #:_____

Preferred Language:_____ Preferred Pharmacy:_____

Home Address : _____

Mailing address: _____ ( ) same as home

Primary Care Provider: _____ Employer:_____

Emergency Contact: _____Relationship:_____Phone #:_____

Primary Insurance:_____ Secondary Insurance: _____ ( ) Card provided

I have an advanced directive: **Yes / NO**
I would like more information on making an advanced directive: **Yes / NO**

"I have reviewed my demographic and insurance information and verify that all information is correct." *Initials* _____

Confidentiality in Communication

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding your health care. Only list numbers you want us to call:

CELL:_____ **HOME**:_____ **WORK**:_____

We need your permission to leave voice mail messages, or give information to a family member who may answer your telephone.

"I give permission to Dr. Fox's office to leave pertinent information regarding my health care and appointments with family members" as listed below:

Name_____ Relationship_____

Name_____ Relationship_____

OR

_____It is my wish that information regarding my health, appointments, and account status NOT BE RELEASED TO ANYONE OTHER THAN MYSELF.

_____ _____
Patient Signature (or Responsible Party / Relationship to patient) Date

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Cancellation Policy

Please help us in providing efficient care to everyone, minimizing wait times for office and surgery appointments by:

- notifying us 48 hours to canceling an office appointment
- notifying us 72 hours prior to canceling a date for surgery

Privacy Practices and Protected Health Information

Patient consent for use and disclosure of protected health information:
I understand that as part of my health care, Dr. Lindsay J Fox, M.D., originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operation such as assessing quality and reviewing the competence of health care professionals

Under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, effective April 14, 2003 we have provided you with a copy of the Notice of Privacy Practices for Health Information (available at front window). This notice describes how medical information about you may be disclosed and your privacy regarding your protected information. Please let us know if you would like a copy to take home with you.

I understand that this provider has the right to change its *Notice of Privacy Practices* from time to time and that I may ask the organization at any time, at the address above, to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that Dr. Lindsay Fox, M.D. is not required to agree to the restrictions requested. I understand that I may revoke my consent in writing; except to the extent that Dr. Lindsay Fox, M.D. has already taken action and reliance thereon.

Authorization for Release of Medical Information

- I authorize the release of any medical information that may be helpful in my treatment **TO** Dr. Lindsay Fox, MD.
- I authorize release of my medical records **FROM** Dr. Lindsay Fox, MD to be sent to my primary physician, referring physician, or any other provider involved in my care.

_____ _____

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Financial Policy

Dr. Fox is committed to providing the highest level of medical and surgical care and professional service. In order to continue to make that commitment to you, we ask that you settle your financial obligation to us in a timely fashion.

Proof of primary and or secondary insurance is required, or eligibility for Medicare, Medi-Cal, or Workers Compensation is the responsibility of the patient/guardian.

Co-pays and deductibles are required at time of visit.

We understand that health insurance and health care is complicated. We want to do our best to assist you with understanding your bill.

Here are some tips with interpreting your EOB (explanation of benefits):

- **Total Charges:** This is the total amount each provider will bill to insurance.
- **Allowed amount:** This is the total amount expected to be paid by insurance and/or patient combined. (It is also called the negotiated amount or contracted amount.)
- **Payable Amount:** This is the amount that the primary insurance will pay.
- **Patient Responsibility:** This is the difference between the allowed amount and the payable amount. This represents any deductibles and co-payments or co-insurance. If you have a secondary insurance they may pay for all or part of this "patient responsibility", depending on your contract.

We will turn delinquent accounts over to a collection agency for payment of funds. However, we are always willing to work with you to make a payment plan to help pay off your bill.

Please contact our billing company **CPR**, with any questions regarding your Bill or EOB,: **phone 800 942 6907**

As Dr. Fox sees patients covered by many different insurance plans, it is impossible for us to be familiar with each individual plan. As the patient, I understand that I am responsible for understanding my own individual health care plan. Prior to surgery, we recommend that you not only talk to your insurance provider, but you also contact:

Mercy Mount Shasta Medical Center Financial Counseling Department:
phone (530) 926-7245

Authorization For Assignment of Insurance Benefits

I hereby authorize payment for medical services that I am to receive to be paid directly to Dr. Lindsay Fox. I also authorize Dr. Lindsay Fox to release any information required by my insurance company in order to process claims.

"I have read, understand, and agree to the above"

_____ _____

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Patient Portal - "Patient Fusion"

We are excited to offer the use of our Patient Portal through our electronic health record system Practice Fusion. Through "Patient Fusion", you can:

- Directly message Dr. Fox (for non-urgent communications)
- Review your medical records
- Download and print your medical records
- *Currently we do not offer online appointment booking and cancellation*

If you are interested in using the Patient Portal, please provide us with your email. You will then get an "invite" to set up an account.

Your email: _____