Ocean Breeze Medical Group, Inc.

Registration Form

By initialing next to the phone number(s) below, I authorize Ocean Breeze Medical Group, Inc, its physicians and staff to provide to me detailed messages on my voicemail regarding medical information such as: test results, medications, referrals, authorization determination, etc. for my benefit of receiving the information in a timely manner.

Name:	Date of birth:	Sex: M/F	Social Security Number:

Address:	City:	State:	Zip Code:

Marital Status:	Spouse Name:	Home Phone Number:	Cell Phone Number:
Single		**INITIAL:**	**INITIAL:**

Occupation:	Employer:	Employer Phone #:

Address:	City:	State	Zip Code:

In case of emergency, name and phone number of person we may contact (not living with you):

Pharmacy Name: **City:** **Phone #:**

Email Address:

I the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Ocean Breeze Medical, Inc, Dr. Davalos, and/or Dr.Ebrahimzadeh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Responsible Party Signature	Relationship	Date

Ocean Breeze Medical Group, Inc.

Notice Of Privacy Practices Acknowledgement

Privacy Official: Ricardo Davalos, M.D.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signature: _____ Date:_____

Patient Name: _____

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Print Name: _____ Relationship to patient: _____

Signature: _____ Date: _____

Please list those individuals and their relationships to you with whom we can communicate via phone and/ or in person **your medical information which may include: test results, diagnosis, plan of care, referrals, medications prescribed, personal discussions, etc.**

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Ocean Breeze Medical Group, Inc. Staff signature/ Witness: _____

Ocean Breeze Medical Group, Inc.

Practice Policies

Welcome to Ocean Breeze Medical Group, Inc. The physicians greatly appreciate you selecting them as your family physician. Our office is committed to offering you state of the art care in a stress-free atmosphere. In order for us to fulfill this commitment to you, we ask that you play a key role and extend the following courtesies:

My Signature below acknowledges my understanding of the following:

Article 1: I understand that my insurance contract is between my insurance company and me. It is the responsibility of the patient to know and understand their medical insurance benefits. I agree that I am required to provide Ocean Breeze Medical Group, Inc. with the most correct and updated information about my insurance, and will be responsible for any charges incurred if the information provided is not correct or updated. I also agree I am responsible for any charges my insurance may not cover. I understand that failure to pay my account or make suitable financial agreements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to collection fees, court fees, attorney fees and any other fees for the collection of my account balance.

Article 2: Ocean Breeze Medical Group, Inc. accepts cash, checks, and Visa/ MasterCard payments. I understand that I am required to pay my co-payment or co-insurance at the time of the service. Any other arrangement must be made prior to the appointment. There will be a fee of $25.00 for a returned check. I agree that full payment and returned check fee will be paid in ten days to avoid dismissal from practice. All outstanding balances greater than $100 or balances in collection must be paid and brought current prior to any appointment.

Article 3: OCEAN BREEZE MEDICAL GROUP, INC. REQUIRES A 24 HOUR CANCELLATION NOTICE. IF CANCELLED WITHIN 24 HOURS OR "NO SHOW" FOR YOUR APPOINTMENT THERE IS A $150.00 MISSED FEE FOR EITHER IN OFFICE OR TELEHEALTH VISITS. A $200 FEE WILL INCUR FOR MISSED PHYSICAL EXAMS. REPETITIVE MISSED APPOINTMENTS WITHOUT NOTIFICATION WILL RESULT IN DISMISSAL FROM THE PRACTICE. ***INITIAL HERE:***

Article 4: Walk in patients will be accommodated but will not supersede those with appointments.

Article 5: Referrals will not be granted over the phone until an Ocean Breeze Medical Group, Inc. physician evaluates the patient. As your referral is processed, elements of your medical record may be forwarded to the specialist along with your referral. I authorize to provide the necessary information to the designated specialist.

Article 6: Ocean Breeze Medical Group, Inc. will phone in a prescription to the appropriate pharmacy only under special circumstances. It is the patients' responsibility to provide the pharmacy's name and phone number. Ocean Breeze Medical Group, Inc. will not refill prescriptions written by another physician. Ocean Breeze Medical Group, Inc. will provide you with enough refills to last until your next appointment. Approval of refill request in between appointments is at the discretion of the physician. Due to liability issues, no refills for controlled substances will be granted over the phone unless the patient is re-evaluated by an Ocean Breeze Medical Group, Inc. physician. Lost prescriptions for a controlled substance will not be refilled. Failure to comply with this policy will result in dismissal from the practice.

Article 7: At the discretion of Ocean Breeze Medical Group, Inc. treatments or consultations may be performed over the phone. A charge of $45.00 will be assessed to the caller, which may not be a covered insurance benefit.

Article 8: I allow Ocean Breeze Medical Group, Inc. to photograph my medical and or surgical condition and their treatments. These pictures may be added to my medical records. On rare occasion, once your identity is concealed, these pictures may be used in scientific, educational, or research purposes.

Article 9: I have been offered information on creating an advance directive and understand that information. If I already have an advance directive, I understand it is my responsibility to provide a copy to Ocean Breeze Medical Group, Inc.

Article 10: If you are a Medicare beneficiary: There are many items that are not covered under the Medicare program. To name a few: Pre-operative exams and associated lab work, and some screening tests. It is your responsibility to be aware of your covered benefits. Federal regulations require that we inform you of the above. Your signature on this form will indicate that you have been informed, and that you will be responsible for charges of this nature, should they occur during one of your visits.

Article 11: If you are a Medi-Cal Beneficiary: Be advised that Ocean Breeze Medical Group, Inc. does not participate with the California Medicaid program and cannot bill your services to the Medi-Cal plan.

Article 12: We may use and disclose medical information to contact and remind our patients about appointments.

Article 13: Ocean Breeze Medical Group, Inc. will not discuss results or other medical information with anyone other than the patient unless written consent is provided on **Notice of Privacy Practices Acknowledgement Form.**

_____	_____	_____
Print Patient Name	Responsible Party Name/Signature	DATE

Submit