



Conditions of Registration

CONSENT FOR TREATMENT: I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of my/the physicians and/or authorized healthcare provider of Sutter Medical Group, Sutter West Medical Group and Sutter Neuroscience Medical Group, Inc. at one of Sutter Medical Foundation's ("SMF") Care Centers.

TRAINING (if applicable): I understand that my physician office may participate in graduate medical education. I authorize the participation in my/the patient's medical care of physicians-in-training, under the direct supervision of the physicians of Sutter Medical Group, Sutter West Medical Group and Sutter Neuroscience Medical Group, Inc.

RELEASE OF INFORMATION: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, SMF may disclose any portion of my/the patient's medical records, including, but not limited to, information about my/the patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any person, regulatory or government agency, or corporation, including but not limited to insurance companies, health care service plans, or workers' compensation carriers, which are, or may be liable for, all or any portion of SMF's charges. To ensure coordination of my/the patient's ongoing care and treatment, I also authorize release of any medical information to my/the patient's primary care physician or healthcare provider and any consulting physicians or healthcare providers participating in my/the patient's care.

ADVANCED DIRECTIVES: Information Brochure on Advance Directives given patient _____ (Staff initials). Patient refused information _____ (staff initial). I am advised that I/the patient have the right to prepare directives concerning health care decisions made by me or on my behalf by individuals that I appoint to do so. I have previously prepared an advance directive ___yes ___no. If "yes", I have given my doctor a copy of the directive ___yes ___no. If "no", I would like someone to discuss advance directive information with me ___yes ___no.

Name and telephone number of individual designated in my Advanced Directive as the person I wish to be contacted to make healthcare decisions on my behalf:

Name: _____ Telephone number: _____

PRIVACY NOTICE: By signing this section, you acknowledge receipt of *Notice of Privacy Practices of Sutter Medical Foundation*. Our *Notice of Privacy Practices* provides information about how we may use or disclose your protected health information. We encourage you to read it in full.

Signature: _____ Date: _____

OFFICE USE ONLY

Patient Name: _____ DOB: ____ / ____ / ____ MRN: _____

FINANCIAL AGREEMENT:

MANAGED CARE HEALTH PLAN (HMO, PPO, etc.): SMF maintains a list of health plan with which it contracts. A list of such plans is available upon request from SMF's Patient Advocate Department at 1-800-866-7724.

- If SMF currently has a contract with my/the patient's health plan, I understand that I am fully responsible to pay directly to SMF only any required co-payment or deductible (as defined within my health plan policy) as well as any charges for treatment or services that are not covered by the plan's policy.
- If SMF does not have a contract with my/the patient's health plan, I understand that I am legally obligated to pay the full charges for any and all services rendered to me.

MEDICARE / MEDI-CAL: SMF is a Medicare and Medi-Cal provider. I understand that I am responsible to pay directly to SMF any required co-payment as well as any charges for treatment for services I have requested and agreed, in advance, to be provided that are not covered by Medicare and/or Medi-Cal.

FEE-FOR-SERVICE (INDEMNITY) INSURANCE: I authorize direct payment to SMF any insurance benefits otherwise payable to me/the patient, or on my/the patient's behalf, for any medical services rendered. If my insurance does not cover all charges, I agree to pay any difference upon request. If my insurance fails to pay within a reasonable time, I understand that I will be required to pay the bill in full. Should the account be referred to an attorney or collection agency for collection, I shall pay actual attorney's fees and collection expenses. I understand that all delinquent accounts shall bear interest at the legal rate.

SELF PAY: I understand that I am legally obligated to pay the full charges for any and all care and services rendered to me/the patient by my/the patient's physicians or healthcare provider. I also understand that financial counselors are available to help me establish a reasonable payment plan should I desire to do so. Should the account be referred to any attorney or collection agency for collection, I shall pay actual attorneys' fees and collection expenses. I understand that all delinquent accounts shall bear interest at the prevailing legal rate.

AUTHORIZATION: The undersigned certifies that he/she has read the information noted above and has been given the opportunity to have any questions answered fully and to his/her satisfaction, and has received a copy of this agreement, if requested. The undersigned further certifies that he/she is 1) the patient, or 2) the patient's legal representative, or 3) is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature (patient/parent)	Date	Witness Signature	Date
Guardian/Representative Signature	Date	Relationship	
Financially responsible party if other than patient or legal representative or guardian			Date

Sutter Medical Foundation

New Change

Adult Registration

Date _____

PATIENT INFORMATION										
NAME (LAST/FIRST/MIDDLE)				DATE OF BIRTH		SEX	SOCIAL SECURITY NUMBER			
AKA (OTHER NAME)				MARITAL STATUS: ___ M ___ S ___ W ___ D						
MAILING ADDRESS				RESIDENCE ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)						
CITY		STATE		ZIP		CITY		STATE		ZIP
HOME TELEPHONE ()				DRIVERS LICENSE NUMBER				STATE		
EMPLOYER NAME				OCCUPATION						
EMPLOYER ADDRESS				CITY		STATE		ZIP		
EMPLOYER TELEPHONE ()				REFERRED BY						
FINANCIALLY RESPONSIBLE PERSON (THIS PERSON WILL RECEIVE SMF BILLING STATEMENTS) <input type="checkbox"/> SAME AS ABOVE										
RESPONSIBLE PERSON NAME				DATE OF BIRTH		SEX	SOCIAL SECURITY NUMBER			
MAILING ADDRESS				CITY		STATE		ZIP		
HOME TELEPHONE ()										
EMPLOYER NAME										
EMPLOYER ADDRESS				CITY		STATE		ZIP		
EMPLOYER TELEPHONE ()				RELATIONSHIP TO PATIENT ___ SPOUSE ___ FATHER ___ MOTHER ___ GUARDIAN						
EMERGENCY INFORMATION										
PERSON TO CONTACT IN AN EMERGENCY (NAME)										
ADDRESS				CITY		STATE		ZIP		
TELEPHONE ()				RELATIONSHIP TO PATIENT ___ SPOUSE ___ FATHER ___ MOTHER ___ OTHER						
INSURANCE INFORMATION (COPY OF INSURANCE CARD IS REQUIRED)										
NAME/PRIMARY INSURANCE COMPANY				NAME/SECONDARY INSURANCE COMPANY						
ADDRESS				ADDRESS						
CITY		STATE		ZIP		CITY		STATE		ZIP
SUBSCRIBER I.D. #		PLAN #		GROUP #		SUBSCRIBER I.D. #		PLAN #		GROUP #
NAME OF SUBSCRIBER		EMPLOYER NAME				NAME OF SUBSCRIBER		EMPLOYER NAME		
RELATIONSHIP TO PATIENT ___ SPOUSE ___ FATHER ___ MOTHER ___ OTHER				RELATIONSHIP TO PATIENT ___ SPOUSE ___ FATHER ___ MOTHER ___ OTHER						
PRIMARY CARE PHYSICIAN				EFFECTIVE DATE		ARE YOU ENROLLED IN THE MEDICARE AUTOMATIC CROSSOVER PROGRAM FOR YOUR SUPPLEMENT INS? ___ YES ___ NO				
WORKER S COMP INFORMATION (COPY OF 1ST INJURY REPORT REQUIRED)										
EMPLOYER NAME				ADDRESS						
TELEPHONE ()				CITY		STATE		ZIP		
WHERE DID THE ACCIDENT HAPPEN? ___ WORK ___ HOME ___ AUTO				DATE OF ACCIDENT/INJURY		FILE NUMBER				
EMPLOYER/RESPONSIBLE PARTY AT TIME OF INJURY										
ADDRESS				CITY		STATE		ZIP		
How did you hear about us?										
<input type="checkbox"/> Health Plan <input type="checkbox"/> Friend/Family <input type="checkbox"/> Referral service <input type="checkbox"/> Advertising <input type="checkbox"/> Employer <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other physician										