ROSAASEN
Family Medicine

Jonathan Rosaasen M.D.
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Phone (805) 492-1015 Fax (805) 492-2035
www.rosaasenmd.com
office@rosaasenmd.com

Patient Information

Last Name _____ First _____ MI ___
Date of Birth _____ Age _____ Sex M / F
Street Address _____ City _____ State ___ Zip Code _____
Social Security # Last Four_____
Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
Circle Preferred way of contact: Home Cell Work Email Can we leave a message? Yes No Can we text message? Yes No
E-Mail Address _____ Marital Status: Single / Married / Divorced / Widowed
Preferred Pharmacy _____

Emergency Information – IN CASE OF EMERGENCY

Name _____ Relationship to patient _____ Phone (____)_____
Address _____ City _____ State _____ Zip Code _____

Primary Insurance Name _____
Subscriber's Name _____ DOB _____
ID # _____ Group # _____
Relationship to Patient _____

Secondary Insurance Name _____
Subscriber's Name _____ DOB _____
ID # _____ Group # _____
Relationship to Patient _____

Medication History

Our electronic system obtains your medication history from the national pharmacy network. This information is not downloaded automatically and requires your consent. Your signature below is your consent for us to obtain this information in order to better evaluate your medical needs. If you decline, please write decline on the signature line.

Assignment of Benefits

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowance for certain procedures, they sometimes refer to as "reasonable and customary fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. **IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT**. In the event the account is turned over for collection, the collection fee and/or legal fees, including attorney fees, shall be your responsibility. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to Rosaasen Family Medicine, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy.

Signature _____ Date _____

Acknowledgement of Privacy Practices

I hereby acknowledge that I have access to a copy of this medical practice's Notice of Privacy Practices upon request. I further acknowledge that a copy of the current notice is posted on our website, and that I will obtain a copy of any amended Notice of Privacy Practices at each appointment upon request.

Signed: _____ Date: _____
Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship: _____

Name of Patient: _____

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Authorization for Medical Treatment

I, _____ (Patient name) hereby authorize Rosaasen Family Medicine, Inc., associates and assistants as designated by Drs. Jonathan or Amanda Rosaasen to perform evaluation and treatment of my medical condition. I further require and authorize Rosaasen Family Medicine, Inc., associates and assistants, to perform additional procedures, as they may deem immediately necessary on a life threatening basis. I understand that elective minor surgical procedures will be consented separately.

I consent to the administration of medications and injections (also consented separately) deemed necessary in the judgment of Rosaasen Family Medicine, Inc., associates and assistants as designated by Drs. Jonathan or Amanda Rosaasen.

Rosaasen Family Medicine, Inc. can release to my insurance company any medical information necessary to process my insurance claim. I hereby assign benefits from my insurance company to be payable directly to Rosaasen Family Medicine, Inc.

I recognize that the practice of medicine is not an exact science, and Rosaasen Family Medicine, Inc. does not guarantee the results of treatment.

NOTICE TO CONSUMERS: I understand that medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov

Signed: _____ Date: _____
Printed Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship: _____

Name of Patient: _____

Financial Policy

Thank you for choosing Rosaasen Family Medicine. The following is our Financial Policy:

- All patients will provide accurate and complete personal and insurance information
- All applicable co-pays, coinsurance, deductibles and personal balances (current and prior) are due at the time of service
- Payment can be made by cash, Visa, MasterCard, or American Express

Insurance: Rosaasen Family Medicine, Inc. participates in plans administered by Blue Cross, Blue Shield, Aetna, Cigna, United Healthcare, and Health Net plans. We are also contracted with Regal Medical Group and Lakeside Medical Group, which administer our HMO plans.
Financial Difficulties: It is your responsibility to disclose any concerns that you might have regarding payment of your bill prior to seeing the doctor. We will make every effort to assist patients who bring this issue to our attention ***before*** services are provided.
Missed Appointments: All appointments not cancelled at least 24 hours in advance will result in a $50.00 charge for the first incident and a $75.00 charge thereafter. Patients with a pattern of canceling or missing appointments will be seen on a walk-in basis only.
Medical Records: Electronic medical record transmission to other treating providers will be provided free of charge. Paper copies can be supplied on a walk-in basis at $0.10 per page.
Forms: Completion of forms not directly related to patient care is not routinely covered by clinical visit fees or by insurance. Because these take a significant amount of physician time, we find it necessary to charge a fee for completion of such forms. Examples include but are not limited to: Jury Duty Excuse, Family Leave Act Application, certain disability forms, accident reports, and certain DMV forms.
Past Due Accounts: Within 30 days of treatment, any additional payment not made at the time of services is expected in full. ***All accounts will be assessed interest charges at a rate of 18% per annum on all unpaid balances greater than 30 days following the DATE OF SERVICE***. We submit claims to your insurance company as a courtesy to all of our patients. If your insurance carrier requires additional information from you in order to process your claim and you do not provide it, you will be responsible for full payment of all services immediately.
Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to Rosaasen Family Medicine, Inc. I hereby instruct and direct my insurance company to pay by check made payable to Rosaasen Family Medicine, Inc. and mailed to ATTN # 12329Y, PO Box 14000, Belfast, ME 04915-4033. I understand that I am personally responsible for payments which my insurance company/managed care company will not cover if they say that an office visit, procedure or pathology, etc… is "not medically necessary", "pre-existing", etc…or related to deductibles or co-payments, or for any other reason they give for non-payment. I also understand that what my carrier considers "non medically necessary" may, on the contrary, be considered medically necessary by this office. Therefore, I agree to hold Rosaasen Family Medicine, Inc. harmless for any medical decisions made by my insurance/managed care carrier which may in any way compromise my best care and result in medical damage, loss or death.

I authorize Rosaasen Family Medicine, Inc. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. I have read, understand and agree to the above Financial Policy.

_____ _____ _____
Date Signature Printed Name