Simi Medical Group, Inc.

DATE: ____/____/____
SEX: ❑ MALE ❑ FEMALE

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME: _____ M.I.:_____
(FULL LEGAL NAME)

HOME ADDRESS:_____
STREET ADDRESS (NO P.O. BOXES) APT. CITY STATE ZIP CODE

HOME PHONE: ( )_____ WORK PHONE: ( )_____ EXT._____

EMAIL ADDRESS:_____ PREFERRED LANGUAGE: _____

DATE OF BIRTH:____/____/____ AGE:_____ BIRTH PLACE:_____ RACE:_____

ETHNICITY: ❑ HISPANIC OR LATINO ❑ NON-HISPANIC OR LATINO ❑ PATIENT DECLINED SOCIAL SECURITY#:_____
(OPTIONAL)

DRIVER'S LICENSE#:_____ ❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ SEPARATED ❑ DIVORCED

PHARMACY INFORMATION

PHARMACY _____ PHONE ( ) _____ FAX ( ) _____

ADDRESS:_____
STREET ADDRESS CITY STATE ZIPCODE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

NAME OF INSURED:_____ RELATIONSHIP:_____

POLICY#:_____ GROUP#:_____ MEMBER/SOCIAL SECURITY# (OPTIONAL):_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____

RELATIONSHIP:_____ PHONE ( )_____

REFERRING/PREVIOUS PHYSICIAN:_____ PHONE ( )_____

FINANCIAL POLICY

INSURED PATIENTS: IT IS YOUR RESPONSIBILITY TO ENSURE THAT WE HAVE THE MOST UPDATED INSURANCE INFORMATION FOR EACH DATE OF SERVICE, THAT YOU AND/OR YOUR DEPENDENTS ARE ELIGIBLE WITH YOUR INSURANCE PLAN AND COVERED (AND PRE-APPROVED, IF APPLICABLE) FOR THE SERVICES BEING RENDERED PRIOR TO RECEIVING CARE. AS A COURTESY, WE WILL SUBMIT CLAIMS TO YOUR INSURANCE COMPANY ON YOUR BEHALF. **PAYMENT OF YOUR CO-PAY IS DUE AT TIME OF SERVICE.**

SELF-PAY PATIENTS: EXPECTED CHARGES WILL BE QUOTED FOR WHICH PAYMENT IN FULL IS REQUIRED DURING CHECK-IN. IF ADDITIONAL CHARGES ARE ACCRUED DURING YOUR VISIT, YOU AGREE TO BE RESPONSIBLE FOR PAYMENT OF THOSE CHARGES BEFORE LEAVING THE OFFICE. IN CASES OF FINANCIAL HARDSHIP, YOU ARE REQUIRED TO MAKE A DEPOSIT AT THE TIME OF SERVICE AND AGREE TO PAY THE REMAINING BALANCE WITHIN 30 DAYS.

I UNDERSTAND AND AGREE TO ABIDE BY THE FINANCIAL POLICY DESCRIBED HEREIN. I UNDERSTAND THAT WHILE MY INSURANCE WILL BE BILLED AS A COURTESY, I AM ULTIMATELY RESPONSIBLE FOR PAYMENT ON MY ACCOUNT.

_____
SIGNATURE DATE

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES, POLICIES AND PROCEDURES.

_____
SIGNATURE DATE