PATIENT REGISTRATION

Acct#	**Last name**	**First name/ Initial**	
Street	City	State	Zip
Phone (preferred)	**Phone** (alternate)	E-mail	
Date of Birth	☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Domestic partner ☐ Not applicable ☐ Separated	
Referred to this office by:	Is this visit related to a work injury? ☐ Yes, date: ☐ No		

EMPLOYMENT INFORMATION

Employer	Phone	Occupation	
Street	City	State	Zip

(REQUIRED BY THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES)

Race:	Declined to Specify	American Indian or Alaskan Native	Asian	Other:
	Black or African American	Native Hawaiian or Other Pacific Islander	White	
Ethnicity:	Declined to Specify	Hispanic or Latino	Not Hispanic or Latino	Other:
Language:	Declined to Specify	English	Spanish	Other:

INSURANCE INFORMATION

Please provide our receptionist with your insurance card(s). We will bill your insurance as a courtesy.

Primary Insurance	Copay **$**	**Policyholder Name**	DOB	Social Security #	**Relationship** ☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance	Copay **$**	**Policyholder Name**	DOB	Social Security #	**Relationship** ☐ Self ☐ Spouse ☐ Child ☐ Other

FINANCIAL RESPONSIBILITY

Insurance authorization, verification and co-payments are the responsibility of the patient or the adult who accompanies a minor to the visit. If your insurance benefits and/or eligibility are not confirmed by your health plan, you will be financially responsible and agree to pay for all charges related to services provided by the Fullerton Neurology and Headache Center. You authorize us to release information to your health plan for the purpose of billing and for that plan to make payment directly to this practice. Please indicate the appropriate health plan option below:

- ☐ **HMO** — **Health Maintenance Organization** with Primary Care Physician/IPA authorization and co-pay.
- ☐ **POS** — **Point-of-Service or Open Access** without prior Primary Care Physician/IPA authorization and with a higher deductible and/or co-pay.
- ☐ **PPO** — **Preferred Provider Organization** with appropriate co-pay, deductible and/or percentage of allowed charges.
- ☐ **EPO** — **Exclusive Provider Organization** may provide more flexibility when medical care is obtained under the plan guidelines. It is your responsibility to check in advance to determine referral restrictions.
- ☐ **Indemnity** — **Indemnity or automobile insurance** with deductible and/or co-pays. No liens accepted. Full payment required within 90 days.
- ☐ **W/Comp** — **Workers Compensation** requires authorization in advance of the appointment. No liens accepted.
- ☐ **Medicare** — **Medicare or Medicare Advantage** (PFFS) without HMO enrollment.
- ☐ **Cash** — Minimum 50% due at time of service. Balance paid within 90 days.

Initials

I am not enrolled, nor intend to enroll, in a state-assistance program (Medi-Cal, CalOptima, Medicaid, MSI, etc).

Date	Signature of Responsibility

This Financial Responsibility Waiver will remain valid from this day forward, to include all future services relating to the above patient.

Fullerton Neurology and Headache Center 100 Laguna Rd #208 Fullerton CA 92835 Ph: 714-738-0800