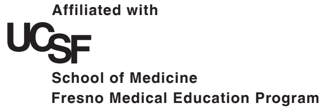


Affiliated with
UCSF
School of Medicine
Fresno Medical Education Program

Acknowledgement of Receipt of Privacy Notice

I have received the University Centers of Excellence Privacy Notice during this visit. I understand that I may obtain a copy of any future revised Notices at any University Centers of Excellence location or on University Centers of Excellence website: www.UniversityMDs.com.

Patient/ Spouse/Nearest Relative/Legal Guardian ______________________ Date ______________

To be completed by University Centers of Excellence Employee if acknowledgement is not signed:

Reason that this acknowledgement was not signed:

_________ Patient indicates received on prior visit

_________ Patient declined to sign

_________ Other

Patient/Representative initials if declined ______________________ Employee's initials ______________

Personal Representative

In the space below, if so desired, please indicate any personal representatives*/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact CCFMG in writing and request the change.

Name(s):____

____

Patient Signature ______________________ Date ______________

**A personal representative as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.*

Central California Faculty Medical Group (CCFMG) and University Centers of Excellence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Affiliated with University Faculty Associates

Shared Electronic Medical Records

We share a electronic medical records system with Community Medical Centers.

Smoke Free Environment

For the health of our patients, employees and visitors, smoking is not permitted at the University Centers of Excellence offices.

Weapon Free Environment

Weapons of any kind are not allowed at any of the University Centers of Excellence offices.

No Show/Appointment Cancellation Policy

We would like to provide you with outstanding service. This however requires your cooperation. If you are unable to keep a scheduled appointment, please call us at least 24 hours in advance so we can give this appointment to another patient. If you fail to keep an appointment or do not call at least 24 hours in advance, you are considered a “No Show” and a $ 35.00 charge may be billed directly to you since it is not covered by any insurance plan.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy.

______________________________ ______________________

Patient Signature (Guarantor if patient is a minor) Date

____

Print Name

Agreement and Authorization for Services Consent Form

I. Consent for Diagnosis and Treatment

I acknowledge and understand that, in presenting myself for treatment and medical care to University Centers of Excellence, also known as Central California Faculty Medical Group and University Faculty Associates, that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the University Centers of Excellence medical staff and personnel. I am aware that medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination.

II. Retention of Information

I understand that University Centers of Excellence may record medical and other information concerning my treatment in electronic and other physical form. Such information is required in the course of my treatment, and may be released by University Centers of Excellence for the purposes authorized on this form. I understand that portions of my records may be disclosed to qualified non-University Centers of Excellence personnel for the purpose of conducting scientific or statistical research, management or financial audits, licensure and program evaluation or other similar purpose. I will not be identified by name or other personally identifying information in any report of such research, audit or evaluation without my express written consent.

III. Release of Information

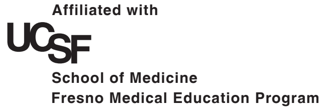
I hereby authorize University Centers of Excellence to release to my insurance companies, employer insurance groups, health plans, Medicare/Medicaid program, its insurance carriers or intermediaries any medical records or other information concerning this treatment to obtain reimbursement on my behalf for the treatment and services provided to me by University Centers of Excellence and the physicians associated with it. I may revoke my consent at any time for any reason by providing written notification to University Centers of Excellence. This authorization shall not conflict with any internal University Centers of Excellence policy regarding release of information which will have priority. This authorization is not intended to allow the release of records regarding my treatment for services requiring a specific authorization under State or Federal Law.

IV. Teaching Program

University Centers of Excellence are affiliated with the University of California, San Francisco School of Medicine (UCSF). UCSF is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary healthcare professions, post-graduate fellows and other trainees may observe, examine, treat and participate, at the request and under the supervision of the attending physician in the patient's care, as part of UCSF's medical education programs.

Please see reverse.

University | Centers of Excellence



Agreement and Authorization for Services Consent Form

V. Assignment of Benefits and Guarantee of Payment

In consideration of University Centers of Excellence and medical services provided to me, I hereby assign University Centers of Excellence and physicians and other professionals associated with University Centers of Excellence all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided.
I agree to pay University Centers of Excellence and the physicians and other professionals associated with University Centers of Excellence the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees.

I have read each of the foregoing, I-V and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

______________________________ ______________
Patient Date

______________________________ ______________
Guardian if patient is under 18 years old Date

______________________________ ______________
Other (record relationship to patient) Date

______________________________ ______________
Witness Date

Affiliated with University Faculty Associates

Financial and Billing Policies

Thank you for choosing the physicians at Central California Faculty Medical Group, University Faculty Associates and University Centers of Excellence (UCOE). We are committed to clinical excellence in meeting your health care needs. We participate with a variety of insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments and other provisions. If you have any questions, call your health plan's member services department their number is listed in your benefit plan booklet or on your ID card.

Inform Us of Changes: If you are a current patient, please inform us if your personal or insurance information has changed since your last visit. The lack of current information may cause delays in care and responsibility for the cost of the entire visit.

Bring Your Health Information: Bring your health insurance information to your visit. This includes identification, all insurance cards, and authorization/referral forms. We will ask you to sign forms such as a release of information, assignment of benefits and possibly additional forms depending on your visit

Co-Payments, Deductibles and Co-Insurance: Co-pay's are due at time of your office visit. Under the terms of our contract with the various insurance plans we cannot waive any co-payments, deductibles or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience we accept cash, checks, debit, VISA, and MasterCard.

Patient Responsibility Balances: All patient responsible balances must be paid in full or a financial arrangement must be made at the time of your visit.

Deposits: For certain procedures, you may be required to pay a deposit or pay for the service in full prior to treatment.

Prompt Payment: We offer a prompt payment discount. Please contact our Billing Department for details.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre existing, or is not a covered service you will be asked to pay prior to the time of service.

HMO/Managed Care Plans: It is your responsibility to make sure a current referral has been obtained for your care with our providers. If a referral has not been obtained by your appointment you may need to reschedule your visit until you have a current referral. We realize this is an inconvenience, but without the referral our physician will not be reimbursed for the services provided.

Workers Compensation: Please bring your claim number, date of injury and employer/workers compensation information. Your claim needs to be open and valid for the condition that we are seeing you for.

Statements: You will not receive a statement until your primary insurance company has fulfilled its financial responsibility or a service is determined to be patient responsibility.

Please see reverse.

Financial and Billing Policies

Who Can Discuss a Bill: Confidentiality is important. Our Patient Account Representatives may only speak with the patient or the person designated in writing by the patient to receive the bill(s) on behalf of the patient.

Thank you for understanding our billing policies. All billing inquiries are handled by our billing staff. If you should have any questions regarding your bill or the status of your account please contact our office at: 559-453-5231, Monday through Friday 8:00 am – 4:30 pm.

I have read, understand, and agree to the above Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to University Centers of Excellence. I authorize University Centers of Excellence to release pertinent medical information to my insurance company when requested, needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform University Centers of Excellence of any changes regarding my personal billing information or my insurance billing information.

______________________________ ____________________
Patient Signature (Guarantor if patient is a minor) Date

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