The Katella Wellness Center

Etsegenet Ayele M.D. — *Internal Medicine* — *Steven Becker D.O.*

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION ONLY

LAST NAME, FIRST NAME	DATE OF BIRTH	PRIMARY LANGUAGE	SEX: MALE ☐ FEMALE ☐
PREVIOUS NAME	SOCIAL SECURITY NUMBER	MARITAL STATUS	STUDENT YES ☐ NO ☐
COMPLETE HOME ADDRESS	CITY		STATE ZIP
HOME PHONE / CELL PHONE	OCCUPATION		DRIVER'S LICENSE NUMBER
EMPLOYER	WORK PHONE		MAY WE CONTACT YOU AT WORK? YES ☐ NO ☐
EMPLOYER ADDRESS	CITY		STATE ZIP
REFERRING PHYSICIAN / PHONE NUMBER	PHARMACY		PHONE NUMBER

EMERGENCY CONTACTS

NAME OF PERSON TO BE NOTIFIED IN CASE OF EMERGENCY	RELATIONSHIP		
ADDRESS	CITY	STATE	ZIP
HOME PHONE / CELL PHONE	WORK PHONE	OTHER PHONE/FAX NUMBER	
NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU	ADDRESS		
HOME PHONE / CELL PHONE	WORK PHONE	OTHER PHONE NUMBER	

GUARANTOR / RESPONSIBLE PARTY

If Guarantor / Responsible Party is SELF please skip this section

NAME	RELATIONSHIP TO PATIENT	DOB	SSN
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE / CELL PHONE	WORK PHONE	DRIVER'S LIC. #	
EMPLOYER	COMPLETE ADDRESS		

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY			PHONE NUMBER
COMPLETE INSURANCE COMPANY ADDRESS			
POLICY / SUBSCRIBER NUMBER	GROUP NUMBER	COVERAGE FROM:	COVERAGE TO:
ANNUAL DEDUCTIBLE NO ☐ YES ☐ AMOUNT: $_____	CO-PAYMENT: NO ☐ YES ☐ AMOUNT: $_____	PERCENTAGE OF COVERAGE :	PAY PLAN
SECONDARY INSURANCE COMPANY	GROUP NUMBER	POLICY NUMBER	EFFECTIVE DATE
COMPLETE INSURANCE COMPANY ADDRESS			PHONE NUMBER

Policy Statement: Our policy is to collect all co-payments, deductibles and non-covered office services at the time such services are rendered. Payment can be made with cash or personal check. I understand that I am financially responsible for all charges that are not covered by my insurance carrier.

Assignment Agreement: The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I, the undersigned, had personally signed the particular claim.

In compliance with Health Insurance Portability and Accountability of 1996, I have reviewed a Copy of Notice of Privacy Practices.

DATE	RESPONSIBLE PARTY'S SIGNATURE

Revised 3/11/05

The Katella Wellness Center, Inc
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Etsegenet Ayele, M.D **Steven Becker, D.O.**

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunization, pap smears etc). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my conditions progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do NOT Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I DO NOT hear from my physician's office within the time specified, I will call the office for my tests results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations, so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, **at any time,** to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____ _____

Patient Signature Date Physician Signature