MONTAGE Medical Group

Last Name	First Name	MI	Suffix □ Jr □ MD □ III □ Sr □ Other: _____	Previous Last Name	Nickname
Social Security Number - -	Date Of Birth / /		Circle One: Male Female		
Street Address	Apt	City	State	Zip	
Race	Ethnicity □ Hispanic or Latino □ Non-Hispanic or Latino	Preferred Language	Religion	Marital Status	
Primary Care Provider					
Cell Phone ☐ This is my preferred phone.	Home Phone ☐ This is my preferred phone.	Email			
Primary Insurance	Primary Insurance ID				
Subscriber Name	Subscriber Date Of Birth / /	Subscriber SSN - -	Relationship to Patient		
Secondary Insurance	Secondary Insurance ID				
Subscriber Name	Subscriber Date Of Birth / /	Subscriber SSN - -	Relationship to Patient		
Emergency Contact Name	Relationship	Phone	Alternate Phone		
Caregiver Name □ None	Phone	Alternate Phone			
Legal Guardian/HealthCare Proxy Name □ None (Please provide copy of Power of Attorney)	Phone	Alternate Phone			

Consent to Treat: The information that I have given to Montage Medical Group is complete and true to the best of my knowledge. I authorize the doctors and staff of Montage Medical Group to administer treatment and procedures deemed necessary and that I find agreeable. I understand that Montage Medical Group implies no guarantees of a cure, and that I have the right to choose my treatment options at any time.

Assignment of Benefits: I authorize the release of any medical information necessary to process my insurance billing. I authorize payment of medical benefits to Montage Medical Group.

Lab Service Disclosure: Please be advised that Laboratory Services are provided by Community Hospital of the Monterey Peninsula, Quest, and/or another outside laboratory. If I wish to select a specific laboratory, I will notify the medical assistant. The lab that receives my specimen(s) will bill me separately for its services.

Use of Cell Phone: I consent to Montage Medical Group, including its business associates, using my cell phone number to call and/or text regarding appointments and to call regarding my care and/or payment of my care. Other federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws

Financial Policy: Montage Medical Group will bill any commercial or governmental insurance on my behalf; however it is my responsibility to know the details of my particular benefit plan. I understand that Montage Medical Group is required to report (or "code") procedures and diagnoses based on the services I receive; consequently, the coding cannot be changed later to cause the insurance company to pay for a non-covered service as this is considered fraudulent practice. I, the undersigned, agree to pay Montage Medical Group as appropriate, in accordance with regular rates and terms. I also agree that I am overall responsible for the entire balance due on the account, including non-covered services, copayments, co-insurance, deductibles, etc. It is the policy of Montage Medical Group to collect co-payments at the time services are rendered. Uninsured patients must pay the total balance due at the time of service. I agree to a $25.00 fee for checks returned for non-sufficient funds.

Signature _____ Date _____

Print Guardian Name (If not patient) _____ Relationship _____

MONTAGE Medical Group

Acknowledgement of Receipt of Notice of Privacy Practices

Name: _____ Date Of Birth: _____

I identify the following individuals as being involved in my care and/or payment of my care. I authorize my healthcare provider, or representative, to discuss any healthcare and/or financial information with the following individuals.*

Name	Relationship	Phone

☐ By checking this box, I authorize this organization to leave me detailed/confidential voice messages about my health or payment of my healthcare at (___) ___-____.

I acknowledge that this form supersedes all previous authorizations.

_____ _____

Signature Date

Privacy Official
100 Wilson Rd, Ste 100
Monterey, CA 93940
Phone: (831) 649-1000

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Signature Date

If not signed by the patient, please indicate your relationship to the patient:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient