

Burlingame Family Health
 1820 Ogden Drive, Suite 200
 Burlingame, CA 94010

PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)					DATE:	
Mr. Mrs. Ms.	Last Name	First Name	Middle Name	EMAIL:		
ADDRESS	Street	City	Zip	HOME PHONE		
SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE	DRIVER'S LICENSE NUMBER		
PATIENT'S EMPLOYER				OCCUPATION		
EMPLOYER'S ADDRESS	STREET	CITY	ZIP	PHONE		
SPOUSE'S NAME				MARITAL STATUS M S D W Sep		
SPOUSE'S EMPLOYER						
REFERRED BY:	NAME	Insurance	Internet	Phone book	Other	
IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THE FOLLOWING SECTION						
RESPONSIBLE PARTY	LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP		
ADDRESS	STREET	CITY	ZIP	PHONE		
SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER				
EMPLOYED BY				OCCUPATION		
EMPLOYER'S ADDRESS	STREET	CITY	ZIP	PHONE		
MEDICAL INSURANCE INFORMATION						
COMPANY 1)				POLICY NUMBER		
COMPANY 2)				POLICY NUMBER		
LIST MEMBERS OF YOUR IMMEDIATE FAMILY:						
IN CASE OF EMERGENCY NOTIFY: Name: Mr. Mrs. Ms.						
ADDRESS	STREET	CITY	ZIP	PHONE		
RELATIONSHIP				BUSINESS PHONE		
<p>Please notify our office if you must cancel an appointment at least 24 hours prior to your appointment time. If you fail to notify us you must be charged for this time. Insurance companies do not pay for missed appointments. I have reviewed a copy of Burlingame Family Health's office policy.</p>						
<hr style="width: 30%; margin: auto;"/> Signature of Patient or Guardian						

Susan Fullemann, MD, Medical Director
 Jerry Warren, Ph.D., Administrative Director

Telephone (650) 697-7202
 Fax (650) 697-7059

NAME

Chronic Medical Problems:

Past Surgeries and year done:

Relationship of any relative with Diabetes?
Heart disease?
Cancer?(what kind)
Osteoporosis?
Any other diseases?

Date

Medications: - with dose and how often taken:

Allergies to medications, etc.:

How much alcohol do you drink ?
Do you smoke, how many a day?
How much caffeine do you drink?

When was your last:
Physical exam
Pap smear
Mammogram
Bone density test
Colon cancer test
Cholesterol test
Tetanus shot

New Patient Insurance Information

Patient Information

Name: _____

D.O.B.: _____

S.S.# _____

Contact# _____

Burlingame Family Health Policy agreement \$185.00

(Will not be charged unless no show)

Credit Card #: _____ exp. _____

Check #: _____

Insurance Information

Insurance: _____ Customer Service # _____

Policy Holder: _____ Effective date _____

Subscriber I.D.# _____ Group# _____

Insurance Rep: _____ Date Verified _____

Taken by: _____ Billing Approval _____

Patient Mailing Address _____

Date _____ Initials _____

Burlingame Family Health
1820 Ogden Drive, Second Floor
Burlingame, CA 94010

LIFETIME SIGNATURE AUTHORIZATION

Name of Beneficiary (patient)_____

Patient's HIC Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Susan Fullemann, MD, known as Burlingame Family Health for any services furnished to me by this physician group.

I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated on the claim submitted, my signature authorizes releasing of the information to the insurer or agency on that form. Because Burlingame Family Health accepts assignment, they have agreed to accept the charge determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, coinsurance, and non-covered services.** Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Signature_____

(Patient or patient's representative)

Date_____

If the beneficiary is unable to sign this form, the patient's representative must complete the following:

Name of representative_____

Relationship to patient_____

Has power of attorney been granted to you?_____

Address_____

Reason that the beneficiary could not sign

Burlingame Family Health
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LIFETIME SIGNATURE AUTHORIZATION

Date: _____ Patient # _____

Name of Beneficiary (patient) _____

Patient's Insurance Carrier _____

Policy Number _____

I request that payment of authorized insurance benefits be made either to me or on my behalf to Susan Fullemann, MD, known as Burlingame Family Health Medical Group for any services furnished to me by this physician group.

I authorize the release of medical information about me to my insurance carrier as needed to determine benefits payable for all related services. If other secondary health insurance coverage is indicated on the claim submitted, my signature authorizes release of this information to the insurer or agency on that form. I understand that **the patient is responsible for all deductible, coinsurance, and non-covered services.** Coinsurance and deductible are based upon the charge determination of my insurance carrier.

Signature _____
(Patient or patient's representative)

Date _____

If the beneficiary is unable to sign this form, the patient's representative must complete the following:

Name of representative _____

Relationship to patient _____

Has power of attorney been granted to you? _____

Address _____

Reason that the beneficiary could not sign

Burlingame Family Health
1820 Ogden Drive, Second Floor
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Susan Fullemann, MD
Dolores Ali, MD
Diana Leykina, MD

Tel: (650) 697-7202
FAX: (650) 697-7059

Member Eligibility Waiver Form

Dear Patient,

Verification of your coverage for health plan benefits relating to injections cannot be made at this time. Services will be provided to you today: however in the event your coverage is not effective, or your plan does not cover these charges, you will be held responsible for payment.

Date: _____

Patient's Name (print): _____

Social Security Number: _____

Subscriber's name _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip code _____

Subscriber's phone number: Day: _____ Evening: _____

I understand my possible financial responsibility for services rendered on this date by the physician listed above. My signature below is an acknowledgment of this understanding.

Name of responsible party: _____

Signature of responsible party _____ Date: _____

BURLINGAME FAMILY HEALTH

Payment Agreement

This is to certify that I give permission to Burlingame Family Health to provide medical evaluation and treatment for myself and / or my child(ren). I and/ or my child(ren) will be treated with respect and honesty throughout treatment.

I understand that I am financially responsible for the evaluation, treatment and other services I receive at Burlingame Family Health. If I am covered by an insurance that is contracted to Burlingame Family Health, I agree to pay any co-payments before service is rendered and to treat the staff of Burlingame Family Health with respect and honesty. A \$10 surcharge will be added to any co-payment that is not paid at the time of service. If I receive services that are not covered by my insurance, I agree to pay for those services before they are rendered. If my insurance has lapsed or is not valid at the time of the service, I agree to pay for all services given when presented with a bill for payment. Should my insurance carrier fail to pay the contracted services for any reason, i.e. bankruptcy, I agree to pay Burlingame Family health for the services rendered to me or my children that were not paid.

All charges are due and payable at the time the service is given. I understand that balances not paid after ninety days of the service will accrue interest at the rate of 2% a month. Should my account be referred to an outside collection agency, attorney or court, all costs of collection, attorney fees, and court costs will be payable by me.

Insurance companies will not pay for missed appointments and Burlingame Family Health needs sufficient notice to fill time slots reserved for patients. I agree that if I do not provide Burlingame Family Health with notice twenty-four hours (excluding weekends) in advance of my initial appointment, I will forfeit my deposit. I agree that if I do not give Burlingame Family Health twenty-four hours notice (excluding weekends) when canceling subsequent appointments I will pay the appointment charge in full. I understand that it is not sufficient to leave a voice mail to cancel an appointment. To avoid being charged I must speak to a staff member, give them the date and time of the appointment and receive a cancellation code from them.

A copy of this authorization shall be considered valid.

(Authorization Signature)

(Date)

Printed Name: _____

Burlingame Family Health Office Policies For Patients

Information for all patients regarding our office procedures:

We really want to make your visits with us be both pleasant and efficient. These procedures help us to provide you with the care you need when you need it.

Office Hours:

Monday through Friday: 8:30 AM -12:30 PM and 1:30 PM-5:30 PM.

We reserve appointments every day for emergencies and acute illnesses.

Please call early in the day to ensure that you can be seen promptly when you are ill.

Lab Hours:

Monday through Friday: 8:30-12:30 and 1:30-3:30

Generally you should arrive fasting unless previously notified. That means eat no food after 10 PM the night before.

Arrival for appointments:

Insurance clearance is a complex process, often requiring telephone calls to numbers that are frequently busy. You will be asked to arrive 15 minutes prior to the time that the medical professional is to see you to clarify these issues and handle billing questions. This will help us to keep on time and prevent you from paying more than your share of medical costs. Patients arriving late will only be seen if there is another appointment available at the time.

Notification about test results:

All abnormal results requiring medication changes and other discussion or interventions require an office visit. You will be called to make an appointment. Do not panic, as most calls of this kind are not serious, just necessary.

Occasionally, a straightforward minor abnormality will be relayed to you by phone by our medical assistant. If you need more detailed explanation or are feeling ill, please ask for an appointment to see a member of our medical staff.

Normal results from our lab:

If you would like a copy of your reports to confirm that they are normal, please request a copy to be sent to you. A charge of \$1.00 covers a portion of our cost for this and makes sending these to you possible. Otherwise you will not be notified that your results are normal. You should ask about them on your next office visit. We cannot provide normal test results over the telephone. You are always welcome to schedule a follow-up appointment to discuss test results after a test is done.

Susan Fullemann, MD, Medical Director
Jerry Warren, Ph.D., Administrative Director

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Burlingame Family Health Office Policies For Patients

An explanatory letter will automatically be sent to all patients having a Dexascan or bone density test. If these results require further treatment, an appointment will be requested in the letter.

Prescription refills:

Conditions requiring prescription medication require regular medical supervision. This is not only sound medical practice, it is the law. Medication refills should be requested during your routine visits. Please bring either a list of medications you are taking or the current medication bottles from home. When your refills run low, you are probably due for an appointment.

Appointment cancellations:

Advance notification of 24 hours for cancelled appointments is required. Charges will be made for missed appointments and insurance companies do not pay for these.

After hour emergencies and messages:

A member of our medical staff is on call whenever we are closed for urgent telephone calls and advice that cannot wait until the office opens. The voice mail will guide you or you can call 692-9532 and enter your telephone number when directed.

Non-urgent messages can also be left for our staff on the voice mail and will be picked up on the next business day.

If you are very ill and need to be seen by a physician before the next business day, please go to the nearest emergency room or urgent care facility or dial 911.