DR. SCOTT T. GHERINI, MD

721 S DORA ST, UKIAH CA, 95482 | PHONE: 707-367-8430| FAX: 707-468-8559
Dr.Gherini@gmail.com

PATIENT INTAKE FORM

Today's Date: _____

Last Name: _____ First Name: _____

DOB: _____ Age: _____ Gender: _____

Marital Status: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

St Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

**Emergency Contact/Guardian Name required if patient is less than 18 years of age*

Emergency Contact/Guardian Name: _____

Relationship to the Patient: _____ Phone#: _____

Primary Insurance Name: _____ Policy ID#: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Secondary Insurance Name: _____ Policy ID#: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services provided. I authorize the release of my medical records or other information necessary to process this claim. Records release: I hereby authorize you to release to any physician, hospital, insurance company employer to attorney any information regarding my present, or past injury.

ACKNOWLEDGEMENT OF UNAUTHORIZED VISIT & PAYMENT RESPONSIBILITY

This is an acknowledgement; the above-named patient wishes to be seen/treated by Dr. Scott T. Gherini despite the fact that he/she may/may not have referral/authorization for this visit. As the subscriber/responsible party for the payment of this service, I understand that my insurance company may not pay for this visit and/or any services rendered which I am ultimately responsible for the total amount due for this visit regardless of insurance. Accounts are due upon receipt and must be paid within 60 days. I have received and read a copy of the notice of private practices (HIPPA).

Printed Name: _____ Signature _____ Date: _____

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FINANCIAL POLICY

Purpose: To ensure consistency in financial collection policies. Continuing to provide quality health care services and to respond to the changing medical care needs of the community is dependent upon receiving the payment for the services it provides: Therefore:

Insurance: As a courtesy, we will bill you insurance company for you. However, it is your responsibility to make sure your account is paid in full regardless of insurance payment. If you have insurance please provide your insurance card and any required information. We will verify your eligibility and benefit information with your insurance company.

Please remember that we have your optimum health and care in mind and that your insurance is a contract between you and your insurance company and possibly your employer, we are not a party to that contract. Not all services are a covered benefit in all contracts. Please make sure you are familiar with your particular plan.

Co-payments and Deductibles: These are responsibility of you, the patient. Co-pays are expected at the time of service, you will be charged a $10.00 billing fee or be sked to reschedule your appointment. Neither co-pays nor deductibles will be written off your account. Payment in full is expected within 90 days of billing or your account maybe turned over to a collection agency.

Self-pay Patients: Payment for services is expected at the time of service. If you cannot pay for this service, you may be asked to reschedule your appointment. Fees for procedures are available upon request.

Out of Country Residents: All Patients who reside outside the United States are required to pay cash for all charges at the time of service regardless of the dollar amount.

Financial Hardships: There are times when making a payment can be financial hardship. It may be necessary to set up a payment plan for those cannot comply with our financial policy. If you are in need if such arrangements, please advice our billing staff as soon as possible. We know times are though please talk to as if needed.

Delinquent accounts: May be assigned to a Collection Agency or attorney, unless prior arrangements are made. Your account will be assessed a $35.00 fee for any balance up to and including the first $100.00 that is sent to collection and an additional $35.00 fee will be assessed for each amount over the first $100.00 up to and including each additional $100.00 increment.

All Co-pays are due at the time of service; Dr. Gherini only takes checks or cash. If not paid at the time of service there will be a $10.00 charge. Thank you, Billing Department

Returned Checks: $25.00 fee

Medical Records: $25.00 fee for providing copy of medical records to the patient or designee, per request.

Other Fees: Form fees (State Disability, FMLA, etc) - $15 per form; SDI form update $10.00. Waterproof cast material - $30.00 per roll.

For Patient: By signing below, I certify, I have read, understand and agree to adhere to this financial policy.

I may request a copy of this financial policy at any time.

Printed Name: _____ Signature _____ Date: _____

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Referring Doctor/Person: _____

Did this injury occur while at work? ☐Yes ☐No If yes Date of injury: _____

If yes, have you filed a claim with your employer/workers compensation? ☐Yes ☐No

Reason for todays visit? _____

_____

How did your injury occur? _____

_____

Which side ☐Right ☐Left ☐Both Dominant hand: ☐Right ☐Left

How long have you had this problem? _____

Have you had any previous surgeries to this area? ☐Yes ☐No

Have your seen a doctor for this problem? ☐Yes ☐No

Have you been treated with ☐Physical Therapy ☐Chiropractor ☐Acupuncture ☐Massage ☐Brace

X-ray taken: ☐Yes ☐No If yes, where: _____

MRI Taken: ☐Yes ☐No If yes, where: _____

Current Symptoms: ☐Pain ☐Swelling ☐Loss of Motion ☐Numbness/Tingling

Other: _____

Have you tried or are you taking medicine for this problem? ☐Yes ☐No

☐Ibuprofen(Motrin/Advil) ☐Aleve/Naprosyn ☐Tylenol ☐Aspirin ☐Celebrex

☐Pain Killers (Vicoden, Darvocet, Tylenol W/ Codeine, Percocet)

☐Cortisone/Steroid Injections Other: _____

Are you unable to participate in daily activities or sports? ☐Yes ☐No

If so what? _____

Please list all previous surgeries: _____

_____

_____

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Please list all current Medications:

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Do you take any herbal supplements (Ginseng, Gingko, Biloba, etc)? ☐Yes ☐No

If so what? _____

Are you allergic to fish, shellfish, or iodine? ☐Yes ☐No

Are you allergic to any medicine? ☐Yes ☐No

If so please list the medicine and reaction (i.e. rash, anaphylaxis, nausea, and hives).

_____

_____

Do you smoke? ☐Yes ☐No How many per day? _____

How long have your smoked? _____

Do you drink alcohol? ☐Yes ☐No How often? ☐Daily ☐Occasionally ☐Rarely

Who do you live with? _____

Are your currently employed? ☐Yes ☐No ☐Retired ☐Disabled ☐ Student

What type of work do you do? _____