

PATIENT INFORMATION	
PATIENT NAME: _____	DATE OF BIRTH: _____
FAMILY SIZE _____ (how many in the household)	HEAD OF HOUSEHOLD _____
ESTIMATED INCOME _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	DATE OF BIRTH _____

**THE INITIAL DEPOSIT DOES NOT REFLECT THE TOTAL COST OF THE OFFICE VISIT**

**Medical patients including OBGYN Services**

Office visits range from \$80 to \$250 depending on the consult, visit type, and complexity of care received by a provider.

**New patients that are self-pay: \$100.00 DEPOSIT** required at time of check-in.

**Established patients that are self-pay: \$80.00 DEPOSIT** required at time of check-in.

This deposit is required prior to services being rendered.

**Dental and Behavioral Health patients**

Other specialties such as Behavioral Health, Dental, and OB may require different or additional office visit copays and/or deposits

If your total visit amount is determined to be higher than deposit received, we collect the balance at the end of your visit or bill you for the difference. If your office visit is determined to be lower than that of the deposit amount collected at the visit and no additional charges are incurred (such as labs and in-office procedures), we will issue a refund for the difference back to the patient or guarantor listed on account.

If special supplies are used during your visit your provider will discuss any additional costs (items may include IUD's, pessaries)

**All copays and coinsurance charges are due at the time of service.**

Additional copays and/or charges may be due in the event that the patient sees multiple members of the extended care team or additional providers from different specialties on the same date of service (For example, PCP visit and behavioral health on the same day OR medical and dental visits on the same day). If you schedule a wellness visit that may be covered by your insurance for no copay or fee, and a medical issue is addressed during this visit, a copay and/or charges may be due as it will be a separately billable service.

PERSON RESPONSIBLE FOR CHARGES IF OTHER THAN PATIENT	
NAME: _____	EMPLOYER: _____
ADDRESS: _____	HOME PHONE: _____
CITY, STATE, ZIP: _____	WORK PHONE: _____
DATE OF BIRTH: _____	CELL PHONE: _____

**By signing below, you acknowledge that you fully understand**

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all health services provided by Adelante Healthcare regardless of whether I have insurance or not. I understand that while Adelante Healthcare contracts with many insurance companies, it is my responsibility to verify with my plan that Adelante Healthcare is a participating provider. It is my responsibility to know what is or is not a covered service. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that I authorize Adelante Healthcare to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that Adelante Healthcare uses an external collection agency in order to collect on any past due accounts and if my bill is not paid in full after 90 days from the date of service my account may be turned over to this agency.

We reserve the right to charge a fee for overdue accounts and returned checks.

I hereby consent to authorize all examinations including physical exams, x-ray and laboratory procedures, which may be necessary in the judgment of the provider for diagnostic purposes. As a teaching institution there may be trainees involved in my care, I understand that I have the right to refuse their services at any time.

I authorize Adelante Healthcare staff to take photographs; I understand that these photographs will be used as a record of my care and for identification purpose. If used, any identifying information will be kept confidential. I understand I will not receive any form of compensation for these photographs.

It is very important for you to keep all scheduled appointments. If you are unable to keep an appointment, you must notify us as soon as possible – we ask for 24-hour notice so we can use those appointment times for other patients. Three missed appointments in a 12-month period will result in a standby appointment status and may lead to a dismissal from the practice. This statement excludes any patients who are receiving behavioral health services.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE