MARIN ENT
REGISTRATION FORM

Today's date:	PCP:

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Email address:	Birth date: / /	Age:	Sex: ❑ M ❑ F ❑ Other

Street address:	Cell phone no.: preferred #? Y N Ok to leave message? Y N ( )	Home phone no.: preferred #? Y N Ok to leave message? Y N ( )

City:	State:	ZIP Code:

Ethnicity (circle): White / Hispanic / Asian / African American / Native American Other_____	Employer: Occupation:	Social Security no.:

Referred to the clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Other

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST.)

Person responsible for bill: ❑ Self ❑ Other If other, name:	Birth date: / /	Address (if different):	Home phone no.: ( )

Sex: ❑ M ❑ F ❑ Other	Employer: ❑ Same as above Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ Aetna ❑ Blue Cross ❑ Blue Shield ❑ Cigna ❑ Heath Net ❑ Medicare ❑ TriCare ❑ United Healthcare ❑ HMO: _____ ❑ Other: _____

Subscriber's name: Sex: ❑ M ❑ F ❑ Other	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative :	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MARIN ENT or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Marin ENT

Romeo C. Agbayani, Jr., M.D.
Daniel W. Flis, M.D.
1000 South Eliseo Drive, Ste 103
Greenbrae, CA 94904

Payment Policy

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. **If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim**.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

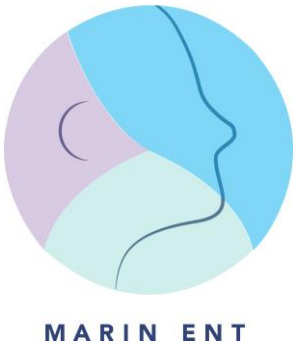
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**



Romeo C. Agbayani, Jr., M.D.
Daniel W. Flis, M.D.
1000 South Eliseo Drive, Suite #103
Greenbrae, CA 94904
Tel (415) 461-9770~Fax (415) 461-6744

AUTHORIZATION FOR RELEASE AND/ OR COLLECTION OF PATIENT INFORMATION.

PATIENT NAME_____

PARENT/GUARDIAN IF MINOR_____

DATE OF BIRTH_____

I understand that in order to coordinate my medical care this office may need to obtain information and records pertaining to my health care from physicians, ancillary providers and different facilities. I am also aware that this office may, at my request, forward information to others participating in my care.

I AUTHORIZE THE OFFICE OF ROMEO C. AGBAYANI, M.D. AND DANIEL W. FLIS, M.D. TO OBTAIN MEDICAL INFORMATION FROM OTHERS PARTICIPATING IN MY HEALTH CARE. THEY MAY ALSO FORWARD INFORMATION TO OTHER PROVIDERS AND FACILITIES AS NECESSARY.

SIGNATURE_____

DATE_____/_____/_____

Romeo C. Agbayani, Jr, M.D.
Daniel W. Flis, M.D.
1000 South Eliseo Drive #103, Greenbrae, CA 94904
(415) 461-9770

Notice of Privacy Practices

To our patients, this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Heath Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with following information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce, or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information
1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of our health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Agbayani /Flis, MDs.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, you request must be made in writing and submitted to Agbayani /Flis, MDs. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Agbayani /Flis, MDs office manager, at 415-461-9770.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office manager of Agbayani /Flis, MDs for further information.

I hereby acknowledge that I have been presented with a copy of Agbayani /Flis, MDs Notice of Privacy Practices.

Name of Patient _____ Date of Birth _____/_____/_____

Signature of Patient (or guardian) _____ Date _____/_____/_____