

# NEW PATIENT PRESCRIPTION FORM

## Rose Clinic, A Professional Medical Corp.

530 Lomas Santa Fe Drive Suite B-1 Solana Beach, CA 92075  
 Phone: 858-755-8955 Fax: 858-755-8959  
 www.roseclinic.us

(Please Print)

Today's date:							
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Occupation:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: (    )		
Street address, cont'd:			Work phone no.: (    )		Cell phone no.: (    )		
City:		State:		ZIP Code:		Email Address:	
How did you hear about Rose Clinic?							
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	<input type="checkbox"/> Internet		
Other family members seen here:							

INSURANCE AND BILLING INFORMATION							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: (    )	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Insurance Co.:		Address of Insurance Co.:			Telephone No.: (    )		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Secondary Insurance Co.:		Address of Secondary Insurance Co.:			Telephone No.: (    )		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Rose Clinic to release any information required to process my medical records to my physician and/or insurance carrier.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

**INTERNAL USE ONLY**

Referring Doctor:

L\_\_ T\_\_ S\_\_

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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been presented with a Notice of Privacy Policies, from Jeanne Stryker MD detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the Privacy Practices describes the personal information your office collect and how and when your office use or disclose that information. It also describes my rights as they relate to my protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations. If I do not accept this disclosure I understand that I must be notified when anything in my medical chart is going to be disclosed, to another physician or medical professional and that I must come in and sign for the medical release form of the items that are requested. I have listed below the following person(s) within my family or close friend(s) whom Dr. Jeanne Stryker can discuss my personal medical information with:

Name:	Relationship to patient:	Home phone no.:	Work phone no.:	Cell phone no.:
1.				
2.				
3.				
4.				
5.				

I accept my medical information may be disclosed under federal and state law.

I hereby authorize payment directly to Dr. Jeanne Stryker for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize Dr. Jeanne Stryker and/ or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian signature:	Date
Print Name:	Date
Reviewed by:	Date

**PAYMENT INFORMATION**

Payment is required in full for each visit. We are happy to provide you with coding information which you may submit to your insurance company for reimbursement. If you would like to keep a credit card on file for payments and or shipments please provide us with your credit card information.

Credit Card Number:	Expiration Date:	VISA, AMEX, MasterCard	Security Code:
	/ /		
Cardholder Name:	Signature:	Date:	/ /

I authorize Dr. Jeanne Stryker to keep my signature on file and charge services and/or products on an ongoing basis. I understand this form is valid unless I cancel the authorization through written notice.

I have read the above billing information and give my consent for treatment at Rose Clinic.

# WAIVER OF LIABILITY

## Rose Clinic, A Professional Medical Corp. / Thermal MD, Inc.

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### MEDICARE INFORMED CONSENT

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (i) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary," under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for the following reason (s):

Medicare usually does not pay for this service.

Medicare usually does not pay for this service/procedure for the reported condition.

Other (describe) \_\_\_\_\_

Rose Clinic/Thermal MD, will courtesy bill Medicare Part B as a non-participating provider. It is your responsibility to verify benefit coverage with Medicare Part B, prior to your visit to our office.

You are expected to prepay for services you receive at our office at the time of your appointment. Upon receipt of payment in full, Rose Clinic/ThermalMD will provide you with an insurance receipt. You may submit this receipt to Medicare Part B for reimbursement (in accordance with your health care benefit coverage).

You are directly responsible to Rose Clinic/ThermalMD for payment. This office does not accept responsibility for dispute, denied or unpaid claims.

### PATIENT AGREEMENT

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment. I acknowledge that I am financially responsible for all charges received from the Rose Clinic/ThermalMD, including services not paid by Medicare Part B. I agree to pay for all cost and expenses incurred at the time of service.

Patient/Guardian signature:

Date

Print Name:

Date

Reviewed by:

Date