2025 ANNUAL PATIENT PACKET

DAWES FAMILY MEDICINE- Thomas M Dawes, Jr MD- A Medical Corporation
116 S Palisade, Ste 210, Santa Maria CA 93454
Phone (805) 934-2488 (fax) 805-934-2480

TODAY'S DATE:

Patient's Last Name:	First Name:	Middle:	Marital Status: [] Single []Married []Partnered [] Divorced []Widowed []Separated		
Former Name:			Birth date: / /	Age :	Sex: [] M [] F
Physical Address:	City, State:		Zip Code:		
Mailing Address _ if same as above					
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Ok to leave message on: []Home# []Work# []Cell#		
Occupation:	Employer:		[] check if Student Where?		
Social Security #:	Email Address:				
For patient under 18 years of age:	Lives with: [] Mother [] Father [] Guardian	Mother:	Father/Guardian:		
		Phone: ( )	Phone: ( )		

PAYMENT INFORMATION:

****PLEASE GIVE YOUR INSURANCE CARD(S) TO THE FRONT DESK AT EACH VISIT TO VERIFY CURRENT ELIGIBILITY****

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Insurance Type: [] HMO [] PPO [] MEDICARE [] OTHER:	Insurance Type: [] HMO [] PPO [] MEDICARE [] OTHER:
Subscriber's Name:	Subscriber's Name:
Subscriber Birthdate: / /	Subscriber Birthdate: / /
Patients relationship to subscriber: [] Self [] Spouse [] Child [] Other:	Patients relationship to subscriber: [] Self [] Spouse [] Child [] Other:

Person responsible for bill (if different from patient):	SS#:	Address (if different):
Home Phone: ( )	Employer:	Work Phone: ( )

IN CASE OF EMERGENCY:

Name of Emergency Contact:	Relationship to Patient:	Phone: ( )	Phone: ( )

PREFERRED PHARMACY:

Local Pharmacy Name:	Street/Intersection:	City:	Phone # if known:

Mail Order Pharmacy (if used):

Office/Financial Policies

Dawes Family Medicine is pleased that you chose our team to help with your healthcare needs. We feel that part of good healthcare practice is to establish and communicate our office and financial policies with our patients.

Please read this document in its entirety and sign prior to your office visit. You will be asked to fill out this patient information form at your initial visit and **each year thereafter**. Be sure to inform us of any changes of information such as insurance, address, telephone number and employer when they occur.

Per calendar year, our office charges an annual fee for our Customized Care Program. This fee helps cover the expenses incurred by the office on your behalf that are not reimbursed by insurance carriers. Insurance does not cover and/or reimburse the annual fee. The Customized Care Program fee is nonrefundable.

C U S T O M I Z E D C A R E P R O G R A M

2025 ANNUAL OFFICE FEE:

$150 Per Member

With the Customized Care Program, you will continue to receive Specialty Care Coordination from our entire medical team – Thomas Dawes, Jr, MD, Dianne Dawes, PA-C, CDE, Amanda Wier, FNP-C, and Tiffany Quinn, NP who have developed relationships for the past 20 years with the top specialists on the Central Coast!

As well as the following:

- More appointment availability both in-office and through Telemedicine
- No additional charge for most forms (unless it is a complex form such as FMLA, Disability or Board and Care forms)
- Home Care Coordination
- Expanded Telemedicine Services through our HIPPA compliant software
- Remote Patient Monitoring

INSURANCE: Your insurance company provides you with proof of insurance*,* ***which must be presented at each visit to check for eligibility***. If proof of insurance is not presented, or if your declared PCP is not affiliated with Dawes Family Medicine, your account will be considered a cash account with full payment expected at time of service.

If we are contracted as preferred providers with your health plan, we will bill your insurance company directly. If we are **not** contracted providers with your insurance company, we expect payment in full at the time of service. We will be happy to provide you with the information you need to bill your insurance company for any eligible reimbursement.

Your individual insurance plan is an agreement between ***you and your insurance company***. Medical offices do not know what medications, procedures, medical facilities and specialists are covered under your plan. Therefore, ***it is necessary for you to know the specific details of your own plan. It is especially important for you to notify us if there are restrictions regarding referrals for services by outside facilities or providers. You may be responsible for charges from those outside providers if they are not preferred providers with your insurance company and/or you have not received the proper authorization prior to receiving services.***

PRIOR-AUTHORIZATIONS: As part of our Customized Care Plan, we work extremely hard to try and obtain prior authorizations on your behalf from your insurance company. Our providers order tests and recommend procedures when medically indicated – independent of any insurance company or outside medical opinion. Even when a prior authorization has been secured, *no guarantee is given by the Insurance Company for payment*. There have been some instances where the Insurance Company is denying payment after the treatment and/or procedure has been performed. The patient is ultimately responsible for any services rendered.

CO-PAYS, NON-COVERED BENEFITS, AND PATIENT BALANCES ARE DUE AT THE TIME OF YOUR VISIT: For your convenience, we accept cash, check, and credit cards. Insurance is billed as a courtesy and the benefits are authorized to be paid directly to the Practice.

PATIENTS ARE RESPONSIBLE FOR THE BALANCE IN FULL IF NOT PAID BY THE INSURANCE COMPANY. If the patient is not prepared to pay the co-pay or balance due, a member of the clinical staff will determine if it is medically necessary for the patient to see the provider. If the patient's condition allows, the appointment will be rescheduled.

PATIENT BALANCE: Patient balances over 60 days past due from statement date may be sent to collections if arrangements are not made with the billing department. Failure to pay your patient balance after 3 statements have been sent could result in a discharge from the practice. Please call the billing department at 934-2488 x105 if you have any questions and/or to discuss necessary arrangements.

RETURNED CHECKS: There is a fee of $30.00 charged for a returned check.

FAILED APPTS & APPTS CANCELED LESS THAN 24 HRS IN ADVANCE: Minimum fee of $100.00 for 1st no-show, $150 for 2nd no-show, and 3rd no-show $200 and you will be discharged from the practice.

ALL THIRD-PARTY BILLING/MOTOR VEHICLE ACCIDENTS: There is a $250 fee for all motor vehicle accident appointments; we can provide you with the required medical notes to file your claim.

WORKERS COMPENSATION: We do not see work-related injuries. You must see the Workers Compensation health care provider(s) that your employer policy is affiliated with.

By signing my name below, I certify that I have read this document. Any questions concerning these policies have been discussed. My signature also certifies my understanding of, and agreement with the Dawes Family Medicine Office Policies

- **I verify that I am fully responsible for the fees and medical services provided by Dawes Family Medicine.**
- **In the event that medical services provided by Dawes Family Medicine are deemed ineligible by my insurance, I am responsible for the full cost of the services.**
- **I understand that my balance is due and agree to pay in full any balance within 45 days of the statement date.**
- **I understand that charges on my account are deemed correct unless I notify the billing manager within 30 days.**
- **I understand that patient balances over 60 days past due from the statement date may be sent for collections if arrangements have not been made with the billing manager.**
- **I understand that the Customized Care Program fee is due annually and is not covered by insurance.**

_____ _____

PATIENT SIGNATURE **DATE**

_____

PRINT NAME

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Dawes Family Medicine – A Medical Corporation for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations for the medical practice. I understand that diagnosis or treatment of me by Dawes Family Medicine– A Medical Corporation may be conditioned upon my consent evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the medical practice. Dawes Family Medicine – A Medical Corporation, is not required to agree to the restrictions that I may request. However, if the medical practice agrees to a restriction I request, the restriction is binding on Dawes Family Medicine – A Medical Corporation and employees.

I have the right to revoke this consent, in writing, at any time except to the extent that Dawes Family Medicine – A Medical Corporation has taken action in reliance of this consent. Otherwise, this consent is valid for a period not to exceed 6 years from the date signed.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, my health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information identifies me.

I understand I have the right to review Dawes Family Medicine – A Medical Corporation Notice of Privacy Practices prior to signing this document. The medical practice's Notice of Privacy Practices will be provided to me to review, if requested. The Notice of Privacy Practices describes in more detail the types if uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Dawes Family Medicine – A Medical Corporation. The Notice of Privacy Practices for Dawes Family Medicine – A Medical Corporation is also posted in the medical office waiting area. The Notice of Privacy Practices also describes my rights and Dawes Family Medicine – A Medical Corporation with respect to my protected health information.

Dawes Family Medicine – A Medical Corporation reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Any questions regarding this document or the Notice of Privacy Practices should be directed to our Privacy Officer• Jennifer Zepeda at (805) 924- 2488 or by email at jzepeda@dawesfamilymedicine.com.

PATIENT OR REPRESENTATIVE SIGNATURE:	**PATIENT OR REPRESENTATIVE PRINTED NAME:**	**DATE**:

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY REQUESTED

□ **NO RESTRICTIONS** □ **RESTRICTION REQUESTED** Restriction Explained**:**

SIGNATURE OF DAWES FAMILY MEDICINE EMPLOYEE:

Tele-Office Medical Appointment CONSENT

Dawes Family Medicine is pleased to offer a new type of medical appointment using updated technology to make more appointments available at our office. We have found that some of the services we provide require expert care and knowledge but don't always need the physical presence of a provider. Such things include updating medications, some routine refills, lab review, and Medicare Wellness Evaluations. Today you are being given the opportunity to participate in this new venture called **Telemedicine.**

CA State Law Telemedicine/Telehealth Definition

"Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers." **Source:** *CA Business & Professions Code Sec. 2290.5*

We are providing a way for you to meet with a health care provider remotely via a HIPAA secure video conferencing network. We will provide technology and assistive devices such as headphones for the hearing impaired. Please be aware that the appointment is limited in scope - it is not for assessing medical emergencies nor can we discuss issues that you were not scheduled for. If the provider feels that a more detailed exam is needed you will be rescheduled for an appointment with a clinician in office.

This is an office appointment and as such, any co-pay, balance or deductible is due at the time of service. The medical assistant will be taking your vitals and setting up the technology for you to have a private conversation with the medical provider. Most insurances cover costs of telemedicine in the state of California. In fact, this service is being encouraged as a means to provide healthcare in underserved areas. Please feel free to ask any questions and if at any time you are not comfortable please let one of our staff know Lastly, we would like your feedback. At the end of your appointment the medical assistant will give you a short survey to fill out about the experience. We welcome your feedback and any suggestions.

We are aware of the trust you put in us to deliver to you quality up to date healthcare. We thank you for that trust and hope that you find this experience to be a positive one as we are trying to create more appointment availability for our patients.

- *I understand that any co-pays, deductibles and/or account balances are due at the time of my Telemedicine Appointment.*
- *I understand that the provider will be communicating with me remotely through secure, HIPAA compliant technology.*
- *I agree to have a telemedicine appointment at Dawes Family Medicine and that this consent will remain in effect until I notify the office otherwise.*

PATIENT NAME (PRINTED): _____ DATE OF BIRTH: _____

PATIENT SIGNATURE: _____ DATE: _____

Consent for Release of Medical Information

Patient Name: _____ **SSN:** ___-__-____

Date of Birth: _____ **Chart#** _____

I, _____, give my permission to have any/and or all of my medical information, including financial, released to the following persons:

****

Name _____ **Name** _____

Address _____ **Address** _____

_____ _____

Phone: _____ **Phone:** _____

Relationship: _____ **Relationship:** _____

****

Name _____ **Name** _____

Address _____ **Address** _____

_____ _____

Phone: _____ **Phone:** _____

Relationship: _____ **Relationship:** _____

****

Patient Signature: _____

Date:_____

Witnessed by: _____ **Title:**_____

(Must be a Dawes Family Medicine employee)