Debra L. Bunger, M.D., B.C.F.E
9055 Soquel Dr. Suite G
Aptos, CA 95003
Phone: 831-708-2919 Fax: 831-708-2937

PATIENT REGISTRATION FORM

Who may we thank for referring you to us?

Name (First, Mid Int. Last)			
Address			
City		State	Zip Code
Home Phone w/ area code	Email		
Cell Phone w/ area code	Gender	Social Security #	
Work Phone w/ area code	Emergency Contact	Emergency Contact Phone w/ area code	
Date of Birth	Relationship to patient		

INSURANCE INFO.

Insurance Plan Name	Insurance Phone w/area code
Insured Name (If Different Than Patient)	
Insurance/ Member ID	Group ID
Self Pay: Yes ☐ No ☐	

Required

PLEASE PROVIDE COPY OF ISURANCE CARD FRONT AND BACK

I authorize payment of medical benefits be made directly to the physician/provider for services rendered and I authorize the release of any medical or other information necessary to process this claim

SIGNED (Insured or authorized) DATE

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Welcome to our office. We are committed to providing the highest quality of services. If you have any questions or concerns about any aspect of our services, please let us know. We strive to provide great customer service in a compassionate, caring environment. However, we are a small office, and therefore are providing you with specific policies which we require to provide you the highest level of care. The policies and procedures listed on this page provide some answers to many of the questions that we are asked.

1. Your care with us is completely confidential, except in those cases required by law - such as suspected child and elder abuse. Our practices comply with the HIPAA (Heath Insurance Portability and Accountability Act). Read our *Notice of Privacy Practices* for details.

We will not release any information about you unless you authorize it. We have *release forms* that you sign to authorize the exchange of information with other doctors.

Other forms, such as disability applications, need to be signed by you for the same reason.

2. By law we may exchange information with your primary care physician without written permission. If you are prescribed medication, it is important to understand, and follow, these guidelines.

Take your medication as prescribed; if you have questions about a medication, ask the doctor.

Remember that some medications need to be taken for 2 to 4 weeks before a noticeable effect.

Continue to take your medication even if you are feeling better.

Do not stop taking medication or change the dose without discussing this with the doctor.

All medication changes are made at appointments. Likewise, we will send in enough refills to last until you need to be seen again for an appointment. Please be sure and let the doctor know if you need refills of medication. We no longer accept refill requests from pharmacies. Prescription refills outside of these guidelines will be charged a fee of $25.00.

If you have not seen the doctor at the frequency required, your refill will not be authorized until you come in for an appointment.

3. Evaluation and medication management are conducted during scheduled appointments.

Please schedule your next appointment within the time range that the doctor recommends or as soon as possible.

Our schedule can fill up quickly, so please notify us at least two full business days in advance to cancel an appointment; otherwise, you may be charged a "no show" fee.

4. Appointments

After a few visits, you may be seen primarily for medication management appointments. These are shorter appointments after you are improving. Although you can bring anyone to any appointment at any time, you must schedule a longer appointment if you are bringing someone new to your appointments, to make time for their questions and concerns. When you make an appointment, please make it the correct length to help the doctor to run on time.

5. Skype:

We offer Skype appointments after your third visit if that is convenient for you and with the physician's permission. Please inquire about this at the front desk if you are interested.

Initial: _____

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Financial Policy

This is an agreement between Dr. Bunger, as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Bunger.
By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show each date of service and any payments or credits applied to your account during the month.

Payment options:
1. You may pay by cash, check or credit card (Visa or MasterCard) on the day that treatment is rendered.
2. If you have insurance, we must preauthorize your visit, so that we may confirm your benefits, eligibility, co-payments, etc. otherwise you will be required to pay for the visit before you see the doctor.
3. If you do not have insurance, the visit must be paid for at the time of the visit.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month. Also, any balance must be paid by your next appointment.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and a higher co-payment from you.

It is not news to anyone that insurance companies are getting more and more difficult to work with. Most psychiatrists are paid about 75% of the fair market rate by insurance companies, and only about 75% of the time. This lowers the effective rate to about half of what psychiatrists who do not take insurance charge! Insurance companies are very strict about reimbursement, and often arbitrarily deny claims or claim to not have received the claim. Therefore it is very important that you understand that while we will make every reasonably effort to bill your insurance company, any unpaid balances are ultimately your responsibility. Your insurance company may tell you differently but that is our very strict policy. Frankly, it is the only way we can stay in business.

If you fail to notify us of a change of insurance with enough time to verify your benefits, you will be required to pay for that day of service in full and we can supply you with a Superbill for reimbursement.

Likewise there may be charges that your insurance company will not cover. This would include paperwork, insurance forms, extensive telephone calls, etc. You will be required to pay for these items as well.

Feel free to contact the office a day or two in advance if you have any questions about your balance. There is not time to resolve billing issues at the time of your appointment.

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Re-billing Fee: A re-billing fee may be imposed on each account over 30 days past due.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Missed appointment fee: If you are late for your appointment, or cancel with less than 2 full business days' notice, you will be charged a fee. This fee must be paid before a new appointment is scheduled. Patients that miss their appointments without notifying the office will be charged a "no show" fee of $35-$100 depending on the length of the appointment. Patients with three missed appointments may be discharged from the practice. The charge for a late cancellation or a no show for the initial evaluation is $100. Your credit card information is necessary to reserve the initial appointment.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Santa Cruz County, California.

The following may and can be charged to the patient:
Any telephone calls that the doctor may make on your behalf may be billed to the patient.
Any paperwork (EDD/disability forms, forms from insurance, etc) outside of office appointments will be charged to the patient.

One of the strategies that insurance companies use to decrease the cost to them of providing healthcare is to require physicians to do excessive paperwork or to make unnecessary telephone calls to get things like medications or visits "approved." This strategy is intended to wear down physicians, so that they are less likely to prescribe these difficult to get approved medications, or request more sessions. To answer this strategy, we charge for all paperwork and telephone calls that are not clinically indicated. This is a charge that your insurance company probably will not pay. In virtually every case, this cost will be nominal compared to receiving a medication that is not appropriate for you, or to paying for a medication that is not approved. We will always consider what is most appropriate as well as most cost effective for you, and discuss with you the various options for your treatment.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

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Workers Compensation: At this time, we cannot accept any Industrial Accident cases.

Credit History: We have the option to report your account status to any credit reporting agency such as a credit bureau.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Signature: _____ Date: _____

Responsible Party:
(if not the patient) _____

Signature: _____ Date: _____

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Authorization to Release Information from your Previous Treating Psychiatrist

Patient Name (please print): _____

I, hereby authorize the release of my confidential medical records and other information from the office of _____
(Name of Previous Treating Psychiatrist)

To Dr. Debra Bunger, for the purposes related to my health care and mental health treatment.

Previous Treating Psychiatrists:

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Patient Signature: _____ **Date:** _____

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Authorization to Release Information from your Previous or Currently Treating Psychologist

Patient Name (please print): _____

I, hereby authorize the release of my confidential medical records and other information from the office of _____
(Name of Previous/Current Treating Psychologist)

To Dr. Debra Bunger, for the purposes related to my health care and mental health treatment.

Previous or Current Treating Psychologist:

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Patient Signature: _____ **Date:** _____

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ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

Patient Name (print):_____ **Birth date:**_____

Maiden or other name (if applicable):_____

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of Debra L. Bunger, M.D., effective April 14, 2003.

Signature (patient or authorized representative):_____

Date:_____

Relationship/authority (if signed by authorized representative):_____

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Attention Medicare Patients

If you have Medicare, please read this carefully. If you do not have Medicare you may skip this page.

Our office has officially opted out of Medicare meaning that we do not submit Medicare claims. It also means that you may not bill Medicare yourself.

If you have secondary insurance we would be happy to give you a Superbill upon request that you can submit to your secondary insurance to be partially reimbursed.

If you do not have a secondary insurance you will be responsible for all payments for services.

Thank you for your understanding.

Print Name: _____

Signature: _____ Date: _____

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AUTHORIZATION TO CHARGE CREDIT CARD

DATE: _____

I, _____, authorize Dr. Debra Bunger to charge $100.00 to the following credit card account should I fail to cancel my initial psychiatric evaluation appointment within **2 full business days**.

Visa ☐ MasterCard ☐

Cardholder's Name: _____

Account Number: _____

Expiration Date: _____

Amount to Charge: _____

Cardholder's Signature: _____

Your signature is required above even if you would prefer to call with your card information