Patient Information Record

Today's Date: _____

Patient's **LEGAL** Name: _____

Last First MI

(As it apears on your insurance card & driver's license.)

Preferred Name: _____ Date of Birth: ____ / ____ / ____

MM DD YYYY

Social Security #: _____ - _____ - _____ Sex: ☐ M ☐ F E-Mail Address: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____

(Please circle the best number to reach you during the day.)

Address: _____

Street Apt. #

_____

City State Zip Code

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: (____) _____

How did you learn about The Stone Clinic? Doctor / Former Patient / Friend / Internet / Yellow Pages / Other?

Name of Referral: _____

Are you interested in supporting The Stone Research Foundation? YES _____ NO _____

Please present your insurance cards to the receptionist.

Insurance Company: _____

ID#: _____ Group#: _____

Payment-in-full is required at the time of service. Most insurance companies cover Stone Clinic services as an out-of-network provider. After each visit, The Stone Clinic will provide you with an itemized receipt containing diagnostic codes and cost information regarding your visit, which you may mail to your insurance carrier for reimbursement. We will be happy to assist you by providing additional clinical information or medical records to your insurance company as needed for claims processing. Should you have Medicare or Medicare-affiliated insurance, a signed contract for services is required (see General Financial Policy). Your signature below indicates you are financially responsible for all charges incurred, you understand unpaid balances over 60 days will be assessed interest unless other arrangements have been made, and that outstanding balances over 90 days will be processed by a Collection Agency. The highest quality of ancillary services such as Physical Therapy, x-ray, and MRI are usually available at The Stone Clinic on the same date of service as your office visit with readings, diagnosis, and treatment provided the day they are administered. However, although same-day service may not be possible at alternative locations such as the local hospital, California Pacific Medical Center, patients are free to choose where they would like to have those prescribed services performed.

Signature of Patient or Legal Guardian: _____

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California,

(800) 633-2322, www.mbc.ca.gov.

3727 Buchanan Street, Suite 300, San Francisco, CA 94123
Email: info@stoneclinic.com www.stoneclinic.com
Tel (415)563-3110 Fax (415)563-3301

General Financial Policy

Payment-in-full is required at the time of service with the exception of the following situation:

- **Surgery** – If Dr. Stone recommends surgery:
  $500.00 scheduling deposit will be collected to reserve your surgery date.
  50% payment of the Total Estimated Cost is required prior to the date of surgery.
  The remaining balance is due no later than two business days after surgery is performed.

X-rays, MRI, supplies, and physical therapy services will incur a separate charge from the physician's examination fee.

Patient Initials: _____

The Stone Clinic offers a number of payment options for your consideration including cash, check, MasterCard, VISA, American Express, Discover, and CareCredit, who offers 0% interest financing and payment plans for medical services. Your signature below indicates you are financially responsible for all charges incurred and you understand that outstanding balances over 60 days will be assessed 1% compounded monthly interest unless other arrangements have been made. Balances over 90 days will be processed by a collection agency, and The Stone Clinic and related parties may send relevant information to assist in the collection process.

I acknowledge having read and understand the above General Financial Policy and authorize The Stone Clinic to release any information required to process my claim.

Signature: _____ Date: _____

Print Name: _____ Telephone: (____) _____

Please select a payment method:

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ CareCredit

By signing below, I hereby authorize The Stone Clinic to securely store and automatically charge the following credit card for services provided by Dr. Kevin R. Stone and The Stone Clinic. An itemized receipt for each payment will be provided to me and the charge will appear on my credit card statement. I agree that no prior authorization will be provided unless the anticipated charge exceeds $10,000.00. I understand this authorization will remain in effect until I cancel it in writing, and I agree to notify The Stone Clinic in writing of any changes in my account or credit card information within 7 calendar days from the date the change occurs. I acknowledge that the origination of credit card charges must comply with the provisions of U. S. law. I certify that I am an authorized user of this credit card and will not dispute these transactions, so long as the transactions correspond to the terms indicated within this authorization.

Credit Card Number: _____ Exp. Date: _____

Security Code: _____ Billing Zip Code: _____

Cardholder Authorization Signature: _____ Date: _____

Or:

I prefer to use the following payment method: ☐ Cash ☐ Check

By signing below, I understand that I am required to make payment-in-full, in person, at the end of every visit, and I will not be eligible to participate in any type of payment plan for the services I receive unless I choose to allow The Stone Clinic to securely store my credit card information and authorize automatic payments.

Guarantor Signature: _____ Date: _____

3727 Buchanan Street, Suite 300, San Francisco, CA 94123
Email: info@stoneclinic.com www.stoneclinic.com
Tel (415)563-3110 Fax (415)563-3301

____ I **DO NOT** have Medicare or Medicare affiliated insurance. (Please sign below.)

____ I **DO** have Medicare or Medicare affiliated insurance. (Please sign below.)

PRIVATE CONTRACT FOR MEDICARE PATIENTS

This agreement is between Kevin R. Stone, M.D. ("Dr. Stone"), doing business as The Stone Clinic, whose principal place of business is 3727 Buchanan Street, San Francisco, CA 94123 and patient _____ , or his or her legal representative, _____, (together, "Patient").

Dr. Stone and The Stone Clinic agree to provide all services and items deemed necessary by Dr. Stone and the staff of The Stone Clinic. In exchange for the Services, the Patient agrees to make payments to Dr. Stone and The Stone Clinic pursuant to The Stone Clinic's Fee Schedule. The Fee Schedule is available to Patient upon request. Patient also agrees, understands, and expressly acknowledges:

◦Patient accepts full responsibility for payment and will make payment in full for the Services, and acknowledges that Dr. Stone and The Stone Clinic will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

◦Patient acknowledges that Medicare's fee limitations and reimbursement regulations do not apply to Dr. Stone's and The Stone Clinic's charges for the Services.

◦**Patient agrees not to bill or submit a claim to the Medicare program or to ask Dr. Stone or The Stone Clinic to bill or submit a claim to the Medicare program with respect to the Services, even if they are covered by Medicare.**

◦Patient is not currently in an emergency or urgent health care situation.

◦Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services, and other supplemental insurance plans may also deny reimbursement for the Services.

◦Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and that he or she is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

◦Patient understands that Medicare payment will not be made for any Services furnished by Dr. Stone or The Stone Clinic that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.

◦Patient acknowledges that a copy of this contract has been made available to him/her.

◦Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

◦Dr. Stone is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

In the event that a court or administrative tribunal with proper jurisdiction holds any provision of this Agreement to be invalid, illegal, or unenforceable, the validity, legality, or enforceability of the remainder of this Agreement shall not be affected.

_____
Date

_____
Patient's Signature or Signature of Patient's Legal Representative and Address

_____
Print Patient's Name or Name of Patient's Legal Representative

_____
Kevin R. Stone, MD, for himself and The Stone Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

The Stone Clinic, 3727 Buchanan St., San Francisco, CA 94123

Phone: 415-563-3110

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- ❑ I would like to receive a copy of any amended Notice of Privacy Practices by email at: _____

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If not signed by patient, please indicate:

Relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incomplete patient
- ❑ Beneficiary or personal representative of deceased patient

Name of Patient: _____