Arch Health Partners
Orthopedics

1955 Citracado Parkway, Suite 200
Escondido, CA 92029
760-743-4789
www.ArchHealth.org

About Your Visit:

Our office is located at 1955 Citracado Parkway, Suite 200, Escondido 92029, just south of Palomar Medical Center. If you are unable to keep your scheduled appointment, please let us know by calling (760) 743-4789, 24 hours before your appointment.

In preparation of your first visit; please bring a picture ID, your insurance card and complete the new patient paperwork before your visit. There are various steps in our registration process that must be completed prior to seeing the doctor, so we ask that you arrive 15-20 minutes before your scheduled appointment. This will help you move through the visit with ease.

Bring the following items with you to your appointment:

- New Patient Forms – please complete all sections and be thorough when completing the health questionnaire. Forms are found online at www.archhealth.org.
- Picture ID
- Insurance card
- Co-payment
- All relevant X-rays, MRIs and test results with written reports
- If you were advised to obtain x-rays in our office prior to your appointment, please arrive 60 minutes before your appointment time and check in with the front desk.

The following is important information that will allow us to better serve your needs.

- We will bill your insurance. If you do not have insurance coverage; payment will be expected at time of service.
- We are unable to bill out of the country insurances; this will require payment in full at the time of visit; a copy of the super bill will be provided to you at the end of your visit.
- All co-pays are due at the time of your visit. We are legally obligated to collect your co-pay.
- All prescription requests require 24-hour notice. As a courtesy to all patients, we are unable to accommodate walk-in patient requests to obtain samples or have prescriptions filled while you wait, this will allow our physicians and staff to attend to patients who are present in the office seeking treatment.
- We will call and obtain insurance eligibility and coverage benefits prior to your appointment. You will be asked to review and sign the information obtained from your insurance. Your signature will indicate you understand your financial responsibility.

We look forward to seeing you soon. Please do not hesitate to contact our office if you have any questions.

Sincerely,

Thomas R. Knutson, M.D.

Arush A. Patel, M.D.

Daniel Barba, M.D.

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PATIENT REGISTRATION INFORMATION

1. Patient Information

Patient Name: ____ Sex: Male_______ Female _______
(Last) (First) (MI)

Street Address: ______________________________ City: ____________________ State: ______ Zip: __________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Date of Birth: ___________/___________/____________ Age: ___________ Social Security #: ____________________
Month Day Year

Marital Status (Check One): Married _______ Single ______ Divorced ______ Widow(er) _______ Child ______

Employment Status (Check One): Employed ___ Retired ___ Student (Full Time) ___ (Part Time) ___ Not Employed: ___

Employer Name: ____________________ Address: ____________________ City/State________________ Zip__________

2. Responsible Party (If different from above)

Patient Name: ____ Sex: Male_______ Female _______
(Last) (First) (MI)

Street Address: ______________________________ City: ____________________ State: ______ Zip: ___________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Date of Birth: ___________/___________/____________ Age: ____________ Social Security #: ____________________
Month Day Year

Marital Status (Check One): Married _______ Single ______ Divorced ______ Widow(er) _______ Child ______

Employment Status (Check One): Employed ___ Retired ___ Student (Full Time) ___ (Part Time) ___ Not Employed: ___
(Check One)

Employer Name: ____________________ Address: ____________________ City/State______________ Zip___________

3. Insurance Information (Please present your insurance card to be photo copied for billing)

Primary Insurance: ______________________________ ID# ____________________ Group# ____________________

Name of person insured: ______________________________ Date of Birth_______/ _______/_______ Relationship to pt: ______________

Secondary Insurance: ______________________________ ID# ____________________ Group# ____________________

Name of person insured: ______________________________ Date of Birth ______/ ______/______ Relationship to pt: ______________________

4. Referral Information

Name of Referring Physician ______________________________ Primary Care Physician: ______________________________

Name of other physicians that care for you: ____

5. Emergency Contact

Name of person not living with you: ______________________________ Relationship ______________________________

Home Phone: ____________________Work Phone: ____________________ Cell Phone: ____________________

Address: ______________________________ City: ______________________________ State: ________ Zip: _____________

Patient Authorization to Treat:

Signature ____ Date: ______________________________

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Reason for Visit

Orthopedic treatment is often a result of an accident or injury, your insurance company may require the details of your visit before processing your claim(s) for payment; this information is often used to determine financial liability. Most insurance companies will not pay claims without this information.

NAME (PLEASE PRINT): ____

If you are here for a reason OTHER THAN AN ACCIDENT, please complete this section

My visit is due to ________________________________ Date first noticed: ______________________

Place occurred (home, work, school, etc) ____

Please describe how this may have occurred: ____

____

____

If you are here DUE TO AN ACCIDENT; please complete this section

My visit is due to an accident: No ☐ Yes ☐ If yes, date of accident: ______________________________

Location of accident (home, work, school, care, etc) ____

Please describe how the accident occurred: ____

____

____

Name of Medical Insurance Company: ____

Is there any other insurance company or entity that may be financially responsible for payment of this claim, such as an automobile insurance, homeowners insurance, student insurance, etc.? If so, please explain and provide any additional information so we can determine who the appropriate entity is to be billed for your services.

Note: Although you may advise us that another entity is responsible for payment of the claims, *our office does not file third party billing*; and if it is determined that a third party is responsible, we will provide you with the necessary paperwork to submit your claims. In the meantime, you are financially responsible for any outstanding bills due Arch Health Partners and payment will be expected upon receipt of the first itemized statement.

My signature below indicates that I have read the above and understand I am financially responsible for all medical care rendered, pending any liability disputes.

Signature: ______________________________________ **Date**: ______________________________