

Blackhawk Medical Group
 4165 Blackhawk Plaza Circle, #100
 Danville, CA 94506
 925-736-7070 925-736-7075

John W. Roberts, M.D. Jonathan Humphrey, M.D.

Name (Last, First, Initial)			Patients Acct #:	Guarantor:
Mailing Address:			City & State:	Zip:
Home Phone #:	Cell Phone #:	DOB:	Gender:	Marital Status:
SSN:	DL#:	Email:		How did you hear about us?
Employer:		Occupation:		Work Phone #:
Employer Address:			City & State:	Zip:
Emergency Contact Name:			Phone #:	Alternate #:
Primary Insurance Info: Please Provide Your Most Current Card At Every Office Visit			Insured Person's Name:	
Insurance Name and Address:			City & State:	Zip:
Subscriber #:	Group #:	PCP Name:	Effective Date:	Copay Amount:
Secondary Insurance Info: Please Provide Your Most Current Card At Every Office Visit			Insured Person's Name:	
Insurance Name and Address:			City & State:	Zip:
Subscriber #:	Group #:	PCP Name:	Effective Date:	Copay Amount:

Family Members Names:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

- I hereby authorize Blackhawk Medical Group to release any information acquired during the course of my examination to my employer and/or insurance company for any work related illness and/or injury, and/or pre-placement or periodic exam, and/or to any referring physician/facility should such referral be necessary for my care.
- I hereby certify that the above information is true and correct. I accept responsibility for all charges for this or subsequent treatment; exempt are work related illnesses and/or injuries which have been authorized by my employer prior to the actual appointment.
- If I am currently insured by a medical plan I will provide a current copy to Blackhawk Medical Group at each and every visit.
- A **\$7.50 Fee For Non-Payment of Co-Pay** will be charged in addition to my co-pay if I am unable to pay my co-pay at the time of service.
- A **\$15.00 Re-Bill Insurance Fee** will be charged if I provide Blackhawk Medical Group with incorrect insurance information at the time of service.
- A **\$25.00 NO SHOW Fee** will be charged for all standard office visits not cancelled more than 12 hours in advance. (15 minute appointments.)
- A **\$100.00 NO SHOW Fee** will be charged for all physicals and extended visits not cancelled more than 24 hours in advance. (30 minute or longer time slots.)
- A **\$25.00 RETURNED CHECK Fee** will be charged to my account for all Non-Sufficient Fund checks returned from the bank.
- I hereby consent to medical treatment by Blackhawk Medical Group.
- I hereby authorize payment of all insurance benefits to Blackhawk Medical Group.

Signature of Patient or Legal Guardian: _____ Date: _____

Pharmacy: _____ City/Location: _____ Phone #: _____

Lab results may be left on the answering machine at this #: _____