902 Santa Fe

902 Santa Fe Avenue, Albany, CA 94706

Christopher Brown, DO

(510) 526-5256 • fax (510) 526-5547
www.christopherbrowndo.com
902santafe@gmail.com

Patient's Last Name: _____ First Name: _____

Address: _____

City: _____ State_____ Zip_____

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

Age_____ Date of Birth ____/_____/_____ Email: _____

*Occupation*_____

Referred by: _____

Patient's condition: _____

_____ Duration of Problem: _____

Doctor: _____ Doctor's Telephone: _____

No. in household _____

If Child: Parent or guardian: _____

Parent 1 Occupation: _____ *Parent 2 Occupation:* _____

Siblings _____

Emergency Contact (other than parent) (name & phone):

_____

Fees:

- **New patient**: Adult - $300, Child under 14 - $200
- **Follow-up**: Adult - $170, Child under 14 - $150

Office Policies:

- 48-hours (2 business days) cancellation notice
- For "no-shows" and late cancellations, you are charged half of treatment fee
- We do not bill insurance directly
- We do not take Medicare/Medical nor Workman's Comp
- Payment is required at the time of your visit. We accept cash, check or credit

I have read and agree to honor all office policies.

Signed_____ Date _____

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MEDICAL RELEASE FORM

Today's Date: _____

Patient Name: _____ Date of Birth _____-_____-_____
Please print

1. Permission to release information to Insurance Carriers:

I give permission to this office to release medical information to my health or automobile insurance company.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

❏ Please contact me when you receive requests for information from my insurance carrier.

2. Permission to Share Information with Health providers:

I give permission to this office to share my medical information with my other health providers so that they may coordinate my care.

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

❏ Please contact me before sharing any information with my other health providers.

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HIPPA NOTICE OF PRIVACY PRACTICE - ACKNOWLEGEMENT OF RECEIPT

I hereby acknowledge that a current copy of the medical practice's Notice of Privacy Practices is available online at www.hhs.gov/hipaa as well as in the reception area. I further acknowledge that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient: _____

Patient/Guardian Signature: _____ _____
Date

_____
(Print Name of Patient/Guardian)

Address: _____

If not signed by the patient, please indicate relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient