

SOUTHWEST INTERNAL MEDICINE SPECIALISTS

Diplomats, American Board of Internal Medicine

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PATIENT REGISTRATION

PATIENT NAME _____
Last First Initial

HOW DID YOU HEAR ABOUT US? _____

Home Address _____

City _____ State _____ Zip _____ Date of Birth _____

Mailing Address (if different) _____

Male/Female _____ Social Security Number _____ Marital Status _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____ Telephone _____

Friend or Relative not living With You:

Name _____ Relationship _____

Address _____ Telephone _____

Medical Insurance Information:

1. Primary Insurance _____ Policy Holder _____
DOB: _____ SSN#: _____

2. Secondary Insurance _____ Policy Holder _____

Name of Spouse or (if a minor) parent _____

Spouse's/Parent's Employer _____ Telephone _____

Authorization and Assignment

I hereby authorize my insurance carrier, attorney or any third-party payer to pay directly to Southwest Internal Medicine Specialists all charges submitted for services incurred by me. I understand I will be responsible for any and all charges not paid by my insurance company. I authorize Southwest Internal Medicine Specialists to release information concerning my medical condition to my insurance company, employer, hospital, physician or attorney for the purpose of processing a claim. I assign payment directly to the physicians at Southwest Internal Medicine Specialists which may be due from the Medicare program or any other insurance company, including supplemental insurance, which may cover in whole or part medical services which I have received. The authorization and assignment shall be valid until I notify Southwest Internal Medicine Specialists in writing of the cancellation. A photocopy of this authorization shall be valid as the original copy.

Signature Date Signature (WITNESS) Date

Name _____ Race _____ Sex _____ Age _____

Handedness _____ L _____ R _____ Height _____ Weight _____

Present Concerns: _____

Past Medical History

Have you ever had:

| | | | | | |
|--------------------|----------|----------------------|------------------|----------|----------------------|
| Chicken Pox | _____ No | _____ Yes When _____ | Hepatitis | _____ No | _____ Yes When _____ |
| Scarlet Fever | _____ No | _____ Yes When _____ | Tuberculosis | _____ No | _____ Yes When _____ |
| Rheumatic Fever | _____ No | _____ Yes When _____ | Pneumonias | _____ No | _____ Yes When _____ |
| Polio | _____ No | _____ Yes When _____ | Venereal Disease | _____ No | _____ Yes When _____ |
| Blood Transfusions | _____ No | _____ Yes When _____ | | | |

Have you ever been treated for:

| | | | | | |
|----------------------|----------|----------------------|----------------------|----------|----------------------|
| Asthma | _____ No | _____ Yes When _____ | Thyroid Disease | _____ No | _____ Yes When _____ |
| Emphysema | _____ No | _____ Yes When _____ | Diabetes | _____ No | _____ Yes When _____ |
| Heart Attack | _____ No | _____ Yes When _____ | Anemia | _____ No | _____ Yes When _____ |
| Heart Failure | _____ No | _____ Yes When _____ | Cancer | _____ No | _____ Yes When _____ |
| Heart Murmur | _____ No | _____ Yes When _____ | Kidney Disease | _____ No | _____ Yes When _____ |
| Abnormal Heartbeat | _____ No | _____ Yes When _____ | Kidney Stone | _____ No | _____ Yes When _____ |
| High Blood Pressure | _____ No | _____ Yes When _____ | Ulcer Disease | _____ No | _____ Yes When _____ |
| Colitis | _____ No | _____ Yes When _____ | Gall Bladder | | |
| Blood Clots | _____ No | _____ Yes When _____ | Disease | _____ No | _____ Yes When _____ |
| Arthritis | _____ No | _____ Yes When _____ | Stroke | _____ No | _____ Yes When _____ |
| Gout | _____ No | _____ Yes When _____ | Epilepsy(seizures) | _____ No | _____ Yes When _____ |
| Abnormal Cholesterol | _____ No | _____ Yes When _____ | Psychiatric Disorder | _____ No | _____ Yes When _____ |
| Chronic Allergies, | | | Glaucoma | _____ No | _____ Yes When _____ |
| Hay Fever | _____ No | _____ Yes When _____ | Colon Polyps | _____ No | _____ Yes When _____ |

Other problems not listed above _____

Last Colonoscopy _____ Last Stress Test _____

List any operations that you have had (include approximate age): _____

Have you ever been treated with X-RAY therapy or radioactive drugs? _____ No _____ Yes When _____

List any medications (and dosages) you currently are taking (include over-the-counter drugs):

List medication allergies

Habits

Tobacco use? No _____ Yes _____
 Did you quit? No _____ Yes _____
 If so, When? _____
 Alcohol? No _____ Yes _____
 Coffee, tea or cola? No _____ Yes _____
 Do you exercise regularly? No _____ Yes _____
 What kind of work
 do you do? _____
 What method of contraception do you use(if applicable)? _____

How many packs per day? _____
 How many packs per years? _____
 Amount per day? _____
 Amount per day? _____
 How often? _____
 Any toxic exposure? No _____ Yes _____

Do any of your family members have or have had:

Cancer No _____ Yes _____
 Heart Attacks No _____ Yes _____
 High blood pressure No _____ Yes _____
 Strokes No _____ Yes _____
 Thyroid disease No _____ Yes _____
 Diabetes No _____ Yes _____
 Anemia No _____ Yes _____
 Kidney disease No _____ Yes _____
 Ulcers No _____ Yes _____
 Other No _____ Yes _____

Family History:

| Family History: | Age | Illness |
|-----------------|-------|---------|
| Father | _____ | _____ |
| Mother | _____ | _____ |
| Brothers | _____ | _____ |
| Sisters | _____ | _____ |
| Sons | _____ | _____ |
| Daughters | _____ | _____ |
| Other | _____ | _____ |

Are you bothered with:

Skin Rashes or Discoloration No _____ Yes _____
 Abnormal Lumps or Glands No _____ Yes _____
 Nausea or Vomiting No _____ Yes _____
 Belly Pain No _____ Yes _____
 Constipation No _____ Yes _____
 Diarrhea No _____ Yes _____
 Bloody or Tarry Stools No _____ Yes _____
 Excessive or Constant Worrying No _____ Yes _____
 Abnormal Tiredness No _____ Yes _____
 Shortness of Breath No _____ Yes _____
 Wheezing No _____ Yes _____
 Chest Pain No _____ Yes _____
 Skipped or Irregular Heartbeat No _____ Yes _____
 Ankle Swelling No _____ Yes _____
 Pain in your Legs when you walk No _____ Yes _____
 Weakness in your Arms or Legs No _____ Yes _____
 Loss of Sensation (numbness) No _____ Yes _____
 Lightheadedness No _____ Yes _____
 Night Sweats No _____ Yes _____
 Weight Loss No _____ Yes _____

Loss of Consciousness(Fainting) No _____ Yes _____
 Unusual or Serious Visual Problems No _____ Yes _____
 Hearing, Problems, Earaches No _____ Yes _____
 Headaches No _____ Yes _____
 Frequent Colds No _____ Yes _____
 Hoarseness No _____ Yes _____
 Frequent or Persistent Cough No _____ Yes _____
 Feeling Lonely or Depressed No _____ Yes _____
 Inability to Sleep Well No _____ Yes _____
 Mood Swings No _____ Yes _____
 Poor Appetite No _____ Yes _____
 Difficulty Swallowing No _____ Yes _____
 Hemorrhoids No _____ Yes _____
 Trouble Urinating No _____ Yes _____
 Arthritis No _____ Yes _____
 Morning Stiffness No _____ Yes _____
 Fever or Chills No _____ Yes _____
 Impotence or Other Sexual Difficulty No _____ Yes _____
 Bruises No _____ Yes _____
 Weight Gain No _____ Yes _____

Please give details of any yes answers or of other symptoms not listed above

Please list any other doctors you currently see:

Female Patients - Do you have any problems with:

Cramps No _____ Yes _____
 Irregular No _____ Yes _____
 Painful intercourse No _____ Yes _____
 Your last menstrual period? _____

Heavy Bleeding No _____ Yes _____
 Discharge No _____ Yes _____
 Last Breast Exam/Mammogram _____
 Last Pap Smear _____
 Last Bone Density Scan _____

Number of pregnancies and any complications _____

Signed

Date



M.J. Galceran, M.D. Aparna Hernandez, M.D. Sarah Army, PA-C Rebekah James, PA-C

HIPAA is an acronym for the **Health Insurance Portability & Accountability Act** of 1996, a federal law. Administrative Simplification section of this Act is of Concern to our practice and requires us to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals and employers
- Healthcare Transactions & Code Sets for transmitting electronic data
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services and will become final in a staged manner.

It will be the policy of **Southwest Internal Medicine Specialists** to release confidential information with signed consent by home telephone, answering machine, work telephone, voicemail and cellular phones. Whenever returning telephone calls and the answering machine picks up, it is our policy **NOT** to leave confidential information if there is no recorded message identifying the residence. Confidential information will **NOT** be left with an unauthorized person who may answer your telephone.

If you would like to have your medial information released to someone other than yourself, please complete the following:

I authorize **Southwest Internal Medicine Specialists** to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

- | | | |
|-------------------|------------------------------|-----------------------------|
| Home Telephone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Answering Machine | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work Telephone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Voice Mail | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cellular Phone | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please List authorized persons:

Spouse/Fiancé: _____

Parent/Guardian: _____

Brother/Sister: _____

Son/Daughter: _____

Friend/Other: _____



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REFERRAL POLICY

Some insurance plans require referrals, or pre-authorizations for services provided at a specialist office, diagnostic center, hospital, etc. Our office does have a referral coordinator on staff to process the referrals, and pre-authorizations through the insurance for patients requiring one. However, it is the responsibility of the patient to notify the referral coordinator of any scheduled appointments they may have in order to obtain a referral, or pre-authorization. Including but not limited to appointment scheduled with a physician or facility recommended by a physician or employee at our office. A verbal recommendation is not a referral.

Due to the ever changing contracts between the insurance companies and medical service providers we do not guarantee that a provider we recommend is in network with your insurance.

A prior notice of at least 3 business days is requested, in order to ensure enough time is given for our referral coordinator to process each request, as well as for your insurance to review the request for referral or pre-authorization. Failure to provide adequate notice may result in the patient having to reschedule their appointment.

A request for referral, authorization, or pre-approval does not guarantee coverage. The insurance company may need to review the request to determine if it is medically necessary according to their guidelines. In the event that the clinical information provided does not meet their criteria for approval, the request will be denied. Should this occur you will be notified of the denial by our office, as long as we initiated that request. Completion of a referral does not guarantee payment by the insurance. The written terms of the contract will apply.

If an insurance plan requires a referral or pre-authorization for services rendered, and the service is provided without approval, coverage may be denied.

I have read and agree to the above stated policy.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____

Patient's Account: _____



M.J. Galceran, M.D. Aparna Hernandez, M.D. Sarah Army, PA-C Rebekah James, PA-C

Patient's Acct # _____

NEW LAB FEE POLICIY

September 1, 2007

Please be advised effective September 1, 2007 there will be a \$20.00 lab convenience fee when using our in house lab. Due to rising overhead costs and decreasing re-imbursement, we are no longer able to provide this service free of charge. Please note this fee is not covered or billable to your insurance company. If you select not to participate with this convenience fee you will be given a lab prescription so that you may have your labs done at your nearest participating provider. This fee is in addition to any other applicable copayments.

NEW FORM POLICY

January 1, 2008

Please be advised effective January 1, 2008 there may be a \$25.00 form filing convenience fee when our Doctors have to fill our paperwork for you. Due to the time it takes for some paperwork to be filled out, we are no longer able to provide this service free of charge. Please not that this fee is not covered or billable to your insurance company.

We thank you for your understanding.

Sincerely,

M.J. Galceran, M.D.
Aparna Hernandez, M.D.

I have read and agree to the above stated policies.

Patient's Signature: _____

Patient's Printed Name: _____

Date: _____

Patient's Acct #: _____

**SOUTHWEST INTERNAL MEDICINE SPECIALISTS
FINANCIAL POLICY**

In order for us to be able to continue to deliver high quality of care, it is necessary to provide a financial policy. PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. Please present your insurance card(s) at each visit. It is your responsibility to provide us with the correct information so that we may submit to your insurance. Failure to do so may make you liable for denied claims.
2. We will collect your deductible, co-payment or payment for non-covered services, along with any patient balance due the time of your visit. We accept cash, checks, Visa, MasterCard and Discover. We cannot bill you for co-pays; they must be made at the time of your appointment.
3. If we do not participate with your insurance, we will file your claims as a courtesy and ask that you follow-up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance, AND 1.5% monthly interest will begin to accrue on your account. Balances are expected to be paid in full within 30 days. If payment on your account is not done in a timely manner, your account may be referred to a collection agency and reported to the credit bureau.
4. **MEDICARE PATIENTS:** We will submit to Medicare for all your covered services. If you have a supplemental insurance, we will also submit that for you as a courtesy. If payment is not received from your supplemental insurance within 30 days of being submitted, we will ask for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
5. **MEDICAID PATIENTS:** We are not participating providers with Medicaid. We ask that you pay for your services at the time of your visit.
6. **HMO-PPO PATIENTS:** If we participate with your plan, we will submit your services to your insurance for you. Your co-payment will be collected at the time of service--no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician you are seeing in our office as your PCP. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. 72 hours notice is required to obtain all referrals. We cannot obtain retroactive referrals. If we do not participate with your plan, we will verify your out-of-network benefits, file your services, and we expect payment of your portion of the services at the time of your visit.
7. **SELF-PAY PATIENTS:** Patients without insurance coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements.
8. **NO SHOW OR MISSED APPOINTMENTS:** We understand there may be times when you are unable to keep an appointment. 24 hours notice must be provided to prevent incurring a cancellation fee. If two appointments are missed without proper notice you will be charged a \$25.00 fee for routine visits and \$50.00 for physicals.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your services. If you have any questions regarding our financial policy, please contact our billing department or practice administrator.

I have read and acknowledge the above financial policy of Southwest Internal Medicine Specialists.

Signature (Patient or Guardian)

Date