SOUTHWEST INTERNAL MEDICINE SPECIALISTS

Diplomats, American Board of Internal Medicine

M.J. GALCERAN, M.D. APARNA HERNANDEZ, M.D.

SARAH ARMY, PA-C REBEKAH JAMES, PA-C

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

5979 Vineland Road, Suite 310, Orlando, FL 32819 (407) 345-0005

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 Colonscopy _____ **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_____	How many packs per day?	_____
Did you quit?	No_____ Yes_____	How many packs per years?	_____
If so, When?	_____		
Alcohol?	No_____ Yes_____	Amount per day?	_____
Coffee, tea or cola?	No_____ Yes_____	Amount per day?	_____
Do you exercise regularly?	No_____ Yes_____	How often?	_____
What kind of work do you do?	_____	Any toxic exposure?	No_____ Yes_____

What method of contraception do you use(if applicable)? _____

Do any of your family members have or have had:		**Family History:**	**Age**	**Illness**
Cancer	No_____ Yes_____	Father	_____	_____
Heart Attacks	No_____ Yes_____	Mother	_____	_____
High blood pressure	No_____ Yes_____	Brothers	_____	_____
Strokes	No_____ Yes_____	Sisters	_____	_____
Thyroid disease	No_____ Yes_____	Sons	_____	_____
Diabetes	No_____ Yes_____	Daughters	_____	_____
Anemia	No_____ Yes_____	Other	_____	_____
Kidney disease	No_____ Yes_____			
Ulcers	No_____ Yes_____			
Other	No_____ Yes_____			

Are you bothered with:

Skin Rashes or Discoloration	No_____ Yes_____	Loss of Consciousness(Fainting)	No_____ Yes_____
Abnormal Lumps or Glands	No_____ Yes_____	Unusual or Serious Visual Problems	No_____ Yes_____
Nausea or Vomiting	No_____ Yes_____	Hearing, Problems, Earaches	No_____ Yes_____
Belly Pain	No_____ Yes_____	Headaches	No_____ Yes_____
Constipation	No_____ Yes_____	Frequent Colds	No_____ Yes_____
Diarrhea	No_____ Yes_____	Hoarseness	No_____ Yes_____
Bloody or Tarry Stools	No_____ Yes_____	Frequent or Persistent Cough	No_____ Yes_____
Excessive or Constant Worrying	No_____ Yes_____	Feeling Lonely or Depressed	No_____ Yes_____
Abnormal Tiredness	No_____ Yes_____	Inability to Sleep Well	No_____ Yes_____
Shortness of Breath	No_____ Yes_____	Mood Swings	No_____ Yes_____
Wheezing	No_____ Yes_____	Poor Appetite	No_____ Yes_____
Chest Pain	No_____ Yes_____	Difficulty Swallowing	No_____ Yes_____
Skipped or Irregular Heartbeat	No_____ Yes_____	Hemorrhoids	No_____ Yes_____
Ankle Swelling	No_____ Yes_____	Trouble Urinating	No_____ Yes_____
Pain in your Legs when you walk	No_____ Yes_____	Arthritis	No_____ Yes_____
Weakness in your Arms or Legs	No_____ Yes_____	Morning Stiffness	No_____ Yes_____
Loss of Sensation (numbness)	No_____ Yes_____	Fever or Chills	No_____ Yes_____
Lightheadedness	No_____ Yes_____	Impotence or Other Sexual Difficulty	No_____ Yes_____
Night Sweats	No_____ Yes_____	Bruises	No_____ Yes_____
Weight Loss	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_____	Heavy Bleeding	No_____ Yes_____
Irregular	No_____ Yes_____	Discharge	No_____ Yes_____
Painful intercourse	No_____ Yes_____	Last Breast Exam/Mammogram	_____
Your last menstrual period?	_____	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	□ Yes	□ No
Answering Machine	□ Yes	□ No
Work Telephone	□ Yes	□ No
Voice Mail	□ Yes	□ No
Cellular Phone	□ Yes	□ No

Please List authorized persons:

Spouse/Fiancé: _____

Parent/Guardian: _____

Brother/Sister: _____

Son/Daughter: _____

Friend/Other: _____

_____ _____

Southwest Internal Medicine Specialists

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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: _____

Southwest Internal Medicine Specialists

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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