Deerwood Family Practice

Patient Demographics

First Middle Last

D/O/B Gender SSN Marital Status

Home Address City State Zip Code

Home Number Cell Number Work Number

E-mail

Employer

Employer Occupation

Emergency contact

Name/ Relation

Home Number Cell Number Work Number

Spouse / Parent / Legal Guardian Details

Name Relation SSN D/O/B

Home Number Cell Number Work Number

16675 Huebner RD, Blding 2 Suite 210,San Antonio, TX 78248
Phone: 210-492-4300 Fax: 210-492-4380

Deerwood Family Practice

Other Information

_____

Language Race Ethnicity Religion

Previous Physicians

_____

Type Name and Information

_____

Type Name and Information

Insurance Information

Responsible Party (Primary Card Holder) Information

_____

Last First Middle

_____

D/O/B Gender SSN Marital Status

_____

Address (if different from patient) City State Zip Code

Primary Insurance

_____

Name of Insurance Company

Secondary Insurance

_____

Name of Insurance Company

Pharmacy

_____

Name of Pharmacy Address Phone

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Deerwood Family Practice

Legal Responsibility Form

THE DATE, EXTENT OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES IS NOT TO EXCEED 24 MONTHS (EXCEPT FOR RESEARCH PURPOSES, STATE "NONE" FOR EXPIRATION DATE). I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE STATED OR REVOKED, THIS AUTHORIZATION WILL EXPIRE IN NINETY (90) DAYS FROM THE DATE BELOW.

I UNDERSTAND AND AGREE TO PAY A REASONABLE COPYING FEE TO COVER THE COST OF TRANSFER. I FURTHER UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT OR PAYMENT OR MY ELIGIBILITY FOR BENEFITS. I MAY INSPECT OR COPY ANY INFORMATION TO BE USED OR DISCLOSED UNDER THIS AUTHORIZATION. I UNDERSTAND THAT PROVIDER'S RECORDS MAY CONTAIN INFORMATION CREATED BY AN ENTITY OTHER THAN **DEERWOOD FAMILY PRACTICE** AND THEREFORE IS NOT RESPONSIBLE FOR THE INFORMATION CONTAINED IN SUCH INCORPORATED INFORMATION (INCLUDING THE ACCURACY, COMPLETENSESS, RELEVANCE, LEGIBILITY OR LACK THEREOF OF SUCH INCORPORATED RECORDS). I EXPRESSLY REQUEST RELEASE OF ALL RECORDS MAINTAINED BY **DEERWOOD FAMILY PRACTICE** CONCERNING ME OR MY CHILD, INCLUDING INCORPORATED RECORDS. I ACKNOWLEDGE THAT **DEERWOOD FAMILY PRACTICE** HAS NO AND ASSUMES NO DUTY TO ME REGARDING THE CONTENT OF OR OMISSIONS FROM SUCH INCORPORATED RECORDS.

I HEREBY RELEASE **DEERWOOD FAMILY PRACTICE** AND ITS PERSONNEL FROM ALL LEGAL RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE. DEERWOOD FAMILY PRACTICE IS NOT RESPONSIBLE FOR COMPLETENESS, LEGALITY, OR OMISSIONS CAUSED BY THE COPYING OF ANY MEDICAL RECORDS FROM ANOTHER INSTITUTION.

_____
Signature of Patient or Legal Guardian

_____ _____/_____/_____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

1 LEGAL GUARDIAN DECLINES AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION
(DATE / INITIALS_____)

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Deerwood Family Practice

OFFICE POLICIES:

1. CANCELLATIONS: We require at least a 24 hour notice for cancellation of appointments so that we may offer your appointment time to another patient. If you do not provide at least a 24 hour notice, you will receive a bill for the **$65 NO-SHOW FEE.**

2. **TARDINESS:** If you are 15 minutes late or more, you may be rescheduled in order to accommodate our other patients' appointment slots.

3. **PRESCRIPTION REFILLS:** Refill requests must be made at least one week in advance and should be faxed from your pharmacy to our office 210-492-4380.

4. **NARCOTICS / CONTROLLED SUBSTANCES:** Narcotics are carefully regulated medications and are generally not prescribed unless absolutely necessary. The providers at Deerwood Family Practice not only limit the use of narcotic prescriptions, but also want the patients prescribed narcotics to understand that if a patient reports the prescription was lost, a replacement prescription will not be issued. A limited number of narcotic medications will be prescribed. When the narcotic course is completed, the patient will be required to schedule an office visit and be seen by the provider. Narcotics refills will not be authorized without an office visit. Patients should be very careful with the prescription, treating it as one would cash. A drug screening is required before narcotics are prescribed.

5. **AFTER HOUR CALLS:** After-hours calls will be answered by our automated service. In case of an urgent matter that cannot wait for the next business day, you may reach the on-call provider. There will be a $25.00 fee for afterhours consultations. We will not call in new prescriptions or refill prescriptions after hours. Please make prescription refills and appointment requests during regular office hours.

6. **MEDICAL RECORDS:** There is a $25.00 fee for release of medical records. This must be paid prior to the release of records as it helps cover the cost of printing and shipping. Please allow one week to process your request.

7. **COMPLETION OF FORMS**: As per the rules adopted by the State Board of Medical Examiners, our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days. Fees for forms are as follows: FMLA $50.00, HANDICAP Placard $5.00, DISABILITY $25.00.

8. **DRUG SCREENING**: All patients are subject to a random drug screening as determined by your provider.

I have read and understand the policies set by **Deerwood Family Practice**

-

_____

Signature Date

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Deerwood Family Practice

NAME_____ DOB _____

Are you allergic to any medications:

_____

Do you take any medications? Please include regular use of over-the-counter medications, vitamins and herbal supplements. Use back of page if necessary. Please place an * by medications needing refills.

Name Strength Instructions

_____

_____

_____

_____

Do you have any of the following medical problems or have been diagnosed with any in the past?

□ Arrhythmia/Irregular Heartbeat	□ Kidney Stones
□ Urinary Incontinence	□ Blood Clot (DVT/ pulmonary embolism)
□ Congestive Heart Failure	□ Fracture- location:
□ Recurrent Bladder infections	□ Carotid Artery Stenosis
□ Pneumonia	□ COPD/Emphysema/chronic bronchitis
□ Meningitis	□ Coronary Artery disease/Heart Attack
□ Erectile Dysfunction	□ Chronic pain/Fibromyalgia
□ Diabetes	□ Crohn's/Ulcerative Colitis
□ Gallstones	□ Pancreatitis
□ ADD/ADHD	□ Eczema
□ GERD/Heartburn	□ Peptic Ulcer
□ Heart Murmur/Valvular Disease	□ Cancer: Type:
□ Osteoarthritis	□ Peripheral Vascular Disease (PAD)
□ Osteoporosis	□ Gout
□ Hepatitis	□ Renal Failure
□ Anemia	□ Enlarged BPH
□ Hyperlipidemia/High Cholesterol	□ Rheumatoid Arthritis/ Lupus
□ Hypertension	□ Asthma
□ Hypothyroidism	□ Sleep Apnea
□ Seizure Disorder	□ Alzheimer's/Dementia
□ Irritable Bowel	□ Stroke/TIA
□ Allergies	□ Headaches/Migraines

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For Women only (please only fill out what is applicable):
Age at First Period:_____Date of last menstrual cycle: _____
Number of Pregnancies:_____Were the all successful deliveries?
If not please explain: _____
Are you using birth control?_____If so, what? _____
Date of last Pap smear:_____Results: _____
Any abnormal Pap?_____if so, please explain: _____
Date of last Mammogram: Results:
Any abnormal Mammograms?_____if so, please explain: _____

Colonoscopies (dates and results): _____

_____

Surgeries (dates and details): _____

_____

Please list medical problems in your family. If none or unknown, please list as well.

Father: _____

Mother: _____

Brother(s): (number of): _____

Sister(s): (number of): _____

Paternal Grandfather: _____

Paternal Grandmother: _____

Maternal Grandfather: _____

Maternal Grandmother: _____

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Deerwood Family Practice

Please give us information about yourself:

Occupation:_____for how long? _____

Any occupational or health hazard exposure? _____

Marital Status: _____

Any domestic violence?_____Stress level at home: _____

Do you have an Advanced Directive or a Living Will? _____

Do you Exercise:_____if yes, duration/frequency: _____

Do you maintain a healthy diet? _____

Have you been on a diet within the last year? _____

Do you consume caffeinated drinks?_____how much per day? _____

Rank your fat intake:_____Rank your salt intake: _____

How often do you miss meals? _____or, Overeat? _____

Are you sexually active?_____any problems with your sex life? _____

Do you Drink alcohol?_____If yes, what type?_____amount? _____

If prior use, when did you quit?_____years of use? _____

Do you or did you use tobacco products? _____

If so what type?_____How much daily/week? _____

When did you start?_____for prior use, when did you quit? _____

Have you ever used any illegal or illicit drugs? _____

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Deerwood Family Practice

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for **Deerwood Family Practice** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Deerwood Family Practice describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Deerwood Family Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Deerwood Family Practice, Attn Shawn Mollica, 16675Huebner Rd, Blding 2, Suite 210, San Antonio TX 78248.

With this consent, **Deerwood Family Practice** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Deerwood Family Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Deerwood Family Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Deerwood Family Practice restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Deerwood Family Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Deerwood Family Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____/_____/_____

Print Patient's Name Date

_____

Print Name of Patient or Legal Guardian, if applicable

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Deerwood Family Practice

Information on Preventative Care Visits

Due to insurance regulations, all physicals, well-woman exams and well-child exams are considered preventative care visits. Most insurance companies cover 100% of one preventive care visit per year. The visits cover general check-ups, routine cancer screenings, immunization and counseling on diet and exercise, child development and vitamin supplements. Unfortunately, insurance companies will not cover non-preventative care issues raised during a preventative care visit. As such, we strongly encourage you to make a separate, follow-up appointment with our doctors if you have medical concerns that fall outside of preventative care. This will prevent your insurance company from billing you extra for your preventative care visit while ensuring our doctors schedule the appropriate amount of time to address your medical concerns. We thank you for your understanding in this matter.

Print name_____

Sign_____

Date of Birth_____/_____/_____

Date_____/_____/_____

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Deerwood Family Practice

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Patient Name **DOB** **SSN**

By signing this authorization, I hereby authorize _____

_____

To release health information including copies of my medical records to the following person(s) or facilities at the locations listed for the purpose described:

Persons/Facility: **Shawn Mollica/Karen Williams PA-C/Deerwood**
Address of Location: **16675 Huebner Rd, Blding 2 Ste 210, San Antonio TX 78248**
Ph: (210)492-4300 Fax: (210) 492-4380

□ At the Request of the Individual / Patient: □School:
□Continuum of Medical Care: □Legal Matter:
□Insurance: □Other *(please specify)*:

INFORMATION TO BE RELEASED

□ENTIRE RECORD	□Immunization record:	□HIV Record:
□Physician Notes:	□Lab Results:	□STD Record:
□Radiology Report:	□Operative Report:	□Psych/Mental Health:
□Billing:	□Alcohol/Substance Abuse	□Other:

- I understand that I have a right to revoke this authorization at any time. *
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.
- I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.
- I understand that signing this authorization does not cancel any rights I have under the other state and federal laws.
- I understand that you will provide information within 10-14 days from the receipt of the request.

Form must be completed before signing

_____ _____

Signature of Individual or Representative Date

***YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION ***

_____ _____

Signature Date

Deerwood Family Practice

Dear Patient,

You will no longer receive statements from us in the mail. We now require a credit or debit card on file with our office.

Why the change?
There are several reasons. First, dealing with Insurance companies consumes an inordinate amount of staff time and resources and contributes to higher costs for patients. There are thousands of insurance companies and all have different fee schedules and exclusions and there is no guarantee that they will pay. We do our best to estimate what they will pay but it is nearly impossible to be exact and at times the patient is left with a balance. The *majority* of the time the balance is less than $100.00. For this reason, **we will no longer send statements (bills) for these balances.** Statements are wasteful of paper, stamps, envelopes and time. Second, things are changing in healthcare, and we need to be sure that balances for which the patient is responsible are paid in a timely manner.

How will I know how much you are going to charge me?
You will receive a letter in the mail from your insurance carrier that explains how much of your office visit they pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your insurance coverage, how much they have paid. We will not charge more than $100.00. If your balance after insurance pays exceeds $100 we will charge the first $100 and notify you of the remaining balance. If paid more than expected, we will issue you a refund.

But wait, I'm nervous about leaving you my credit card.
We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. We access your information on this site only to process a payment. Unlike some retail stores that have been featured in the news recently for data breaches due to skimping on protective technology, we follow the Payment Card Industry Data Security Standards to the letter and will not compromise your data security. Medical practices are used to having to secure information under HIPAA laws, and we already have policies in place for any credit card information we come into contact with. We use Retriever Medical/Dental Payments, Inc. and all of our transactions are processed through Practice Management BRIDGE®. For more data visit http://www.retrievermed.com/distinctions/secure-processing/
Keeping the patient's card on file, offsite, in an encrypted payment gateway enhances security because there are fewer human touches in the process that can invite fraud. With a credit card on file system, after the initial swipe, the patient doesn't even have to bring the card to the visit.

What if I need to dispute my bill?
We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error.

What if I don't want to leave a credit card on file or I don't have a credit card?
This is not a problem. You can pay for your services in full today and we will file your insurance. We will have the insurance company reimburse you. In the event, they erroneously send us the check we will promptly refund you.

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Deerwood Family Practice

Deerwood Family Practice will verify benefits, estimate patient potion and file all insurance documents for either option. It is still the patient's responsibility to understand their coverage and that there is no guarantee of payment from any insurance company. Your contract is with your insurance company.

What if I have more questions?
Our staff is happy to speak with you about your account at any time.

No Show and Cancellations for appointments
No Show and cancellations for appointments with less than 24 hours' notice will incur a fee of $65.00. When a patient fails to show up for an appointment or cancels last minute this prevents other patients from having that time and affects the quality of care we can offer to all patients. These will be charged to the card on file.

Please choose one of the following options:
Options: Check box and initial next to the preferred option

- ☐ I opt to pay in full in have my insurance company reimburse me and not leave a credit card on file. I agree to promptly pay any no show or cancellation fees within 10 days of occurring_____
- ☐ I authorize Deerwood Family Practice to charge my credit card ending in _____ for any remaining balance after my insurance has paid not to exceed $100 and any no show or cancellation fees. If my balance exceeds $100 the first $100 will be charged and I will be sent **one statement** of any remaining balance and agree to pay within 30 days after being notified._____

Deerwood Family Practice will verify benefits, estimate patient portion and file all insurance documents for either option. It is still the patient's responsibility to understand their coverage and that that there is no guarantee of payment from any insurance company. Your contract is your insurance company.
This agreement is in effect as long as I use insurance. I also understand that if my credit card is declined and/or my balance is not paid within 30 days from the date insurance pays, I will pay in full for future visits and have my insurance reimburse me. I will notify Deerwood Family Practice promptly if my credit card number changes or expires.

Patient Name: _____ Date: _____
Patient Signature: _____

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Deerwood Family Practice

Lab Draw Consent

Deerwood Family Practice cannot guarantee nor do we obtain prior authorization for any blood draws/specimen handling or processing. It is the patient's responsibility to know what labs or tests are covered by their insurance. If you have any questions regarding your coverage for blood draws and lab processing, please call your insurance prior to your appointment to verify that it is a covered service under your plan. Self- Pay patients must be aware that the fee for labs drawn will be collected at the time of the draw.

Due to numerous laboratories and the contract requirements of each, it is impossible to be affiliated with them all. Deerwood Family Practice is affiliated with *Accu Reference Laboratory, Singulex & Avanti Laboratories (for Urine drug screens).* All blood drawn and specimens obtained *here* will be processed, analyzed and billed through one of these entities.

Blood draws with proper physician orders are welcome to have testing off site at their insurance specified lab of choice; however, all pathology *must* be done in the office.

By signing below you acknowledge and accept responsibility if these labs are out of network; and that Deerwood Family Practice will NOT be responsible for any denied claims and the patient will be billed for services that are not covered by their insurance.

_____ _____

Signature of Patient/Responsible Party Date signed

_____ _____

Print Name Date of Birth

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