RodriguezMD
Community Care-Cuidado Comunitario
771 Old Norcross Road Ste 120 Lawrenceville GA 30046
770-670-6920 FAX 770-670-6927

Billing and Registration Form

LASTNAME ______________________________ FIRST NAME______________________________

DATE OF BIRTH ___/___/____ SOCIAL SECURITY #_____-____-________ SEX (M / F)MARITAL STATUS______________

MAILING ADDRESS____

CITY _______________________________ STATE _________________ ZIP CODE __________________

PHONE # ________________________________ OTHERS ________________________________

EMAIL ____

EMERGENCY CONTACT & PHONE ____

EMPLOYER INFORMATION:

COMPANY NAME ______________________________ WORK PHONE ________________________ EXT ________

ADDRESS ____________________________ CITY ________________________ STATE _____ ZIP CODE _____________

BILLING INFORMATION:

NAME OF RESPONSIBLE PARTY (if other than self) ____

ADDRESS ______________________________ CITY __________________________ STATE ____ ZIP _________

RELATIONSHIP ________________________ DATE OF BIRTH ___/___/_____ PHONE NUMBER ______________________

INSURANCE INFORMATION:

Please give your card to the receptionist to copy

INSURANCE CARRIER(S)____

ID#____________________________***GROUP#***_____________________ ***RELATIONSHIP***________________________

I authorize the release of any medical information necessary to process this claim. (REQUIRED) Signature____________________________Date ___________	I authorize payment of medical benefits to my physician for services provided. (REQUIRED) Signature__________________________Date ____________

Patient History Form for Current Visit

Patient Name____ Date of Birth____________________

What medical concerns can we assist with today?

____

____

Current Medications:

Medication	Dose (mg/mcg)	Number of times taken daily

Are you allergic to any medications? ☐ Yes ☐ No

If yes, to which medications? ____

Social History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many packs per day? _________

Do you drink alcohol, beer, or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? ___________________

Do you currently drink coffee, pop, tea, or energy drinks? ☐ Yes ☐ No

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seatbelts when driving? ☐ Yes ☐ No

Do you wear a helmet while riding a bike? ☐ Yes ☐ No

Have you have had any of these symptoms recently? (Please circle)

☐Cough	☐Change in Vision	☐Sinus pain	☐Leg cramps
☐Bloody nose	☐Swollen/painful joints	☐Allergy symptoms	☐Heartburn
☐Thoughts of suicide	☐Headache	☐Breathing problems	☐Diarrhea
☐Eye pain/runny eyes	☐Dizziness	☐Chest pain	☐Vomiting
☐Decreased hearing	☐Fainting	☐Palpitations	☐Rash
☐Abdominal pain	☐Hemorrhoids	☐Pain with urination	☐Urinating frequently
☐Back pain	☐Foot/ankle pain	☐Nerve pain	☐Trouble sleeping/snoring
☐Sore Throat	☐Swollen lymph nodes		

Females: Gynecological History

First day of your last menstrual period?____

Past Medical History Form

Patient Name____ Date of Birth_____________________

Have you ever been hospitalized overnight? ☐ Yes ☐ No

Have you been tested or vaccinated for hepatitis A, B, or C? ☐ Yes ☐ No

Last TB screening _____________________________________

Last tetanus shot ______________________________________

Which of the following conditions are you currently being treated or have been treated for in the past? (Please check the box)

☐ Heart disease/murmur/angina	☐ Shortness of breath	☐ Eye disorder/glaucoma
☐ High cholesterol	☐ Asthma	☐ Seizures
☐ Low blood pressure	☐ Lung problems/cough	☐ Stroke
☐ High blood pressure	☐ Sinus problems	☐ Headaches/migraine
☐ Heartburn/ reflux	☐ Seasonal allergies	☐ Neurological problems
☐ Anemia/blood or bleeding problems	☐ Tonsillitis	☐ Depression/anxiety
☐ Swollen ankles/vein problems	☐ Ear Problems	☐ Psychiatric care
☐ Diabetes	☐ Kidney/bladder problem	☐ Liver problem/hepatitis
☐ Arthritis	☐ Cancer	☐ Ulcers/colitis
☐ Thyroid Problem	☐ Sexually transmitted disease	☐ Prostate problems
☐ Corrective lenses/glasses	☐ Hearing loss	☐ Rheumatic fever
☐ Hernia	☐ Kidney stones	☐ Eating disorder

Please describe any current or past medical treatment not listed above

____

Please list your past surgeries

____

____

____

____

Family History

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or blood disease	____________________
Cancer	____________________
Diabetes	____________________
Glaucoma	____________________
Heart disease	____________________
High blood pressure	____________________
Mental Illness/depression	____________________
Stroke	____________________
Other serious illness	____________________

Females: Gynecological History

How many times have you been pregnant? __________

Date of last Pap smear __________

Have you had an abnormal Pap smear? ☐ Yes ☐ No

Date of last mammogram? __________

Have you ever had a breast biopsy? ☐ Yes ☐ No

Pharmacy that you want to use: ______________________________

City______________________ **Phone#** ______________________________

☐ I consent to allow Rodriguez MD to request my Medication History, from any heath provider.

Consent to Use or Disclose Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow Rodriguez MD to use or disclose my protected health information for treatment, payment and health care operations.

- Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.

- Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.

- Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Rodriguez MD.

I consent to allow Rodriguez MD to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Rodriguez MD to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Rodriguez MD to disclose protected health information to another covered entity for health care operations activities, provided that Rodriguez MD and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

Name of patient____Date________________________
(Please Print)

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Signature of Person Authorizing Consent

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Relationship to patient

OFFICE POLICIES AND PROCEDURES

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_________**INSURANCE:** To properly file your insurance claim(s), we must obtain a current copy of your insurance card each time you visit our office. This will help your insurance pay your claims in a timely manner and save you from being billed. In the event you do not provide proof-of-insurance, payment will be expected at the time of service. Further, if you provide us with incorrect insurance information, you will be responsible for the bill and we will bill you directly. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee.

- _________It is also your responsibility to read and understand your own insurance policy. Certain services and procedures may/may not be covered depending on own insurance policy.
- _________The following circumstance may result in you being billed directly.
  - We are not a participating physicians in your plan
  - Insurance coverage is not in effect at the date of visit
  - We are not your primary care provider as designated by your insurance.
  - Non-covered lab work is ordered/performed.
  - A service is performed that is not covered by your insurance or denied for the reason “not medically necessary”
  - There is a deductible on your insurance or there are other terms in you insurance plan that mean insurance will not cover some or all of the visit
- _________Co-payment is due at the time of service by the person bringing the patient for the visit. If you do not have your co-pay we will bill you for a $15 administrative fee. If someone other than the parent or guardian is bringing the patient, a notice stating approval of the visit must be signed by the parent/guardian and presented at check-in.

- _________High Deductible Insurance Plans**:** If you have a high deductible insurance plan, it could be the case that basic office visits may not be covered. If this is the case, we will charge 80% of allowable visit charge at the time of the visit, this removes costly follow up administration costs and ensure you have not outstanding debit issues form the visit. If the insurance company later covers the cost of the visit, we will issue a refund. If you are unsure please contact your insurance provider in advance of the visit to check what costs will be covered under your insurance plan.

It is the patient’s responsibility to ensure appropriate insurance cover for visit and service charges, if not covered, you will be responsible for the charges.
<u>If you are not sure, please call your insurance company before the visit.</u>

_________**UN-PAID BILLS:** All out-standing bills are billed and due within 30 days, patients will be sent three reminder statements and then unpaid bills over 90 days will be sent to a collections agency. **THE PATIENT IS RESPONSIBLE FOR ANY COSTS NOT COVERED BY YOUR INSURANCE COMPANY.** There will be a collections fee added to the unpaid bills that are sent to collections. Please call the office as soon as possible if you receive a bill that you believe is incorrect so that we may explain the details and work to resolve before we sent to the collections agency. We will not be able to schedule appointments for patients in collections; outstanding bills in collections need to be settled before a new appointment can be made.

_________**WEB PORTAL:** We are completely electronic paperless office, all laboratory results will available via our web portal along with various details of your visit to our office. We will issue you a log in ID and password to access the portal that will give you access to useful information and services. The web portal will enable access to your laboratory results following review by the doctor, we will contact you directly if there are any sort of abnormal test results and immediate follow up is required.

_________**ABUSIVE or THEATENING BEHAVIOR:** We value our patients and understand that medical conditions at times, can be very stressful, however we cannot accept abusive or threatening behavior to members of staff or Doctors. Abusive behavior will result in the dismissal as a patient from the practice. If you have a complaint or concern, please address them to the General Manager.

_________**REFERRALS:** Referrals may be needed for specialists, emergency room visit, urgent care visit, etc. It is your responsibility to determine if your insurance requires a referral for health care visits outside of our office. If you do need a referral, please contact our office with an appointment date and time. We need 3 working days to obtain a referral from your insurance.

_________**LABS X RAYS, OR OTHER AMBULATORY CARE SERVICES:** If labs, x-ray, or other ambulatory care service are required beyond your office visit, it is your responsibility to know your insurance company covers you to go for these services. Each insurance company contracts with different companies.

I have read and understand the above mentioned policies, and notices.

Print name ____

Signature____________________________________ Date_______________