771 Old Norcross Road, Ste 120,
Lawrenceville, GA 30046
(770)670-6920 / FAX (770)670-6927
Email: fax@rodriguezmd.org

Billing and Registration Form; Forma de Registracion facturacion

LASTNAME Apellido _____ **FIRST NAME** Nombre_____

DATE OF BIRTH Fecha de Nacimiento ____/____/_____ **SOCIAL SECURITY** Seguro Social _____-_____-_____ **SEX** Sexo (M / F)

MARITAL STATUS Estado Matrimonial _____ LANGUAGE **Lenguage**_____

MAILING ADDRESS Direccion_____

CITY Ciudad _____ **STATE** Estado _____ ZIP **CODE** Codigo Postal _____

PHONE Telefono _____ OTHERS Otros _____

EMAIL Correo Electronico _____

EMERGENCY CONTACT & PHONE Contacto de Emergencia y Telefono _____

Pharmacy that you want to use / Que farmacia Usa _____

City/ Ciudad_____ **Phone/ Telefono# _____**

EMPLOYER INFORMATION; Informacion del Empleador**:**

COMPANY NAME Nombre de la Compañia _____ **PHONE** Telefono _____

INSURANCE INFORMATION Informacion del Seguro**:**
Please give your card to the receptionist to copy; *Porfavor permita su tarjeta para copiarla.*

INSURANCE CARRIER *Nombre del Seguro* _____

ID *Numero* _____***GROUP*** *Grupo* _____

I authorize the release of any medical information necessary to process this claim. (REQUIRED) Yo Autoriso a entregar cualquier informacion medica necesaria para procesar esta Solicitud (REQUERIDO) **SIGNATURE** Firma_____ **DATE** Dia _____	**I authorize payment of medical benefits to my physician for services provided. (REQUIRED)** Yo Autoriso el pago del servicio medico recibido, (REQUERIDO) **SIGNATURE** Firma_____ **DATE** Dia _____

PATIENT HISTORY Historia del Paciente

NAME Nombre _____ **DOB** Fecha de Nacimiento_____

CURRENT MEDICATIONS / MEDICAMENTOS ACTUALES

Medication Medicamento	**Dose (mg/mcg)** Dosis (mg/mcg)	**Number of times taken daily** Cuantas veces al dia lo toma

Are you allergic to any medications? Es ud allergico algun Medicamento? □ **Yes** / Si □ **No** / No

If yes, to which medications? / A cual Medicamento? _____

SOCIAL HISTORY / HISTORIA SOCIAL

Do you currently smoke or chew tobacco? /Actualmente fuma o mastica tabaco? □ **Yes**/Si □ **No**

If no, have you in the past? si no, Lo ha usado anteriormente? □ **Yes**/Si □ **No / How many packs per day?** Cuántos paquetes por día? _____

Do you drink alcohol, beer or wine? Bebe cerveza, vino o alcohol? □ **Yes**/Si □ **No**

If no, have you in the past? Si no, Ha Bebido en el pasado? □ **Yes**/Si □ **No / How many drinks per week?** Cuantas Bebidas por semana? _____

Do you currently drink coffee, pop, tea, or energy drinks? Usted actualmente bebe café, pop, té o bebidas energéticas? □ **Yes**/Si □ **No**

Do you exercise daily/weekly? Hace ejercicio diarios/semanales? □ **Yes**/Si □ **No**

Do you use seatbelts when driving? Utiliza cinturones de seguridad cuando conduce? □ **Yes**/Si □ **No**

Do you wear a helmet while riding a bike? Lleva casco mientras monta bicicleta? □ **Yes**/Si □ **No**

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

Han tenido recientemente cualquiera de estos síntomas? (Por favor haga un circulo)

□ **Cough** / Tos □ **Change in Vision** / Cambio en la visión □ **Sinus pain** / Sinusitis □ **Bloody nose** / Sangrado por nariz

□ **Swollen/painful joints** / Articulaciones hinchadas/dolorosos □ **Allergy symptoms** / Alergias □ **Thoughts of suicide** / Pensamientos de suicidio □

Headache / Problemas de dolor de cabeza □ **Breathing problems** / Problemas respiratorios □ **Eye pain/runny eyes** / Problemas con los ojos □

Dizziness / Mareo □ **Chest pain** / Dolor de pecho □ **Decreased hearing** / Problemas de audición □ **Fainting** / Desmayos

□ **Palpitations** / Palpitaciones □ **Abdominal pain** / Dolor abdominal □ **Hemorrhoids** / Hemorroides □ **Pain with urination** / Dolor al orinar

□ **Back pain** / Dolor de espalda □ **Foot/ankle pain** / Dolor de pies □ **Nerve pain** / Dolor en los nervio □ **Sore Throat** / Dolor de garganta □

Swollen lymph nodes / Ganglios linfáticos hinchados □ **Heartburn** / Acidez □ **Trouble sleeping/snoring** / Problemas al dormir-Ronquidos

□ **Vomiting** / Vómitos □ **Leg cramps** / Dolor de pies □ **Urinating frequently** / Frecuencia al Orinar □ **Diarrhea** / Diarrea □ **Rash** / Brotes

Females: Gynecological History / Mujeres: Historia Ginecológica
First day of your last menstrual period? / Primer día de su último periodo menstrual? _____

Past Medical History Form

NAME Nombre _____ **DOB** Fecha de Nacimiento_____

Have you ever been hospitalized overnight? / Ha sido usted hospitalizado? □ **Yes**/Si □ **No**

Have you been tested or vaccinated for hepatitis A, B, or C?/ Se ha vacunado contra la hepatitis A, B o C? □ **Yes**/Si □ **No**

Last TB screening / Último test de detección de TB _____

Last tetanus shot / Última Antitetánica _____

Which of the following conditions are you currently being treated or have been treated for in the past? (Please circle)
Cuál de las siguientes condiciones están actualmente siendo tratadas o han recibido tratamiento en el pasado? (por favor, haga un circulo)

Heart disease/murmur/angina / Enfermedad cardíaca, soplo/angina □ **Shortness of breath** / Falta de aliento

Eye disorder/glaucoma / Trastorno de ojos/glaucoma □ **Stroke /** Infarto □ **Tonsillitis /** Amigdalitis

High cholesterol / Colesterol alto □ **Asthma** / Asma □ **Seizures /** Convulciones **Arthritis**

Low blood pressure / Presión arterial baja □ **Lung problems/cough /** Problemas del pulmón /tos **Cancer**

High blood pressure / Presión arterial alta □ **Sinus problems** / sinositis □ **Headaches/migraine /** Dolores de cabeza y migraña

Heartburn/ reflux / Acidez y reflujo □ **Seasonal allergies** / Alergias □ **Neurological problems /** Problemas neurológicos

Anemia/blood or bleeding problems / Anemia/problemas sanguíneos □ **Depression/anxiety /** Depresión y ansiedad

Swollen ankles/vein problems / Tobillos hinchados □ **Ear Problems** / Problemas de oído **Diabetes**

Psychiatric care / Atención psiquiátrica □ **Ulcers/colitis /** Ulceras/colitis □ **Eating disorder /** Desorden Alimenticio

Kidney/bladder problem / Problemas de riñón u orina □ **Liver problem/hepatitis** / Problemas hepáticos/hepatitis

Sexually transmitted disease / Enfermedades de transmisión sexual □ **Prostate problems** / Problemas de próstata

Corrective lenses/glasses / Lentes/gafas □ **Hearing loss** / perdida de la audicion □ **Rheumatic fever /** Fiebre reumática

Hernia □ **Prostate problems /** Problemas de próstata □ **Kidney stones** / Piedras del riñón □ **Thyroid Problem** / Tiroides

Please describe any current or past medical treatment not listed above / Describa cualquier tratamiento médico actual o pasado no mencionado anteriormente

_____

Please list your past surgeries / Ha tenido alguna cirugía Anteriormente?

_____

_____

Family History / Historia familiar

Has any member of your family (including children and parents) had any of the following illnesses?
Cualquier miembro de su familia (incluidos los niños y padres) han tenido alguna de las siguientes enfermedades:

Illness / Enfermedad **Which family member?** Qué miembro de la familia?

Anemia or blood disease / De la enfermedad de anemia o sangre _____

Cancer _____

Diabetes _____

Glaucoma _____

Heart disease / Enfermedad del Corazón _____

High blood pressure / Presión alta _____

Mental Illness/depression / Salud mental/depresión _____

Stroke / Embolia _____

Other serious illness / Otras enfermedades _____

FEMALES: GYNECOLOGICAL HISTORY / Mujeres Historia Ginecologicas

How many times have you been pregnant? Cuántas veces ha estado embarazada? _____

Date of last Pap smear / Fecha de última Papanicolaou _____

Have you had an abnormal Pap smear? / Ha tenido un Papanicolaou anormal? ☐ Yes ☐ No

Date of last mammogram? Fecha de última Mamografía? _____

Have you ever had a breast biopsy? Alguna vez ha tenido una biopsia de mama ☐ Yes ☐ No

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

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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)

_____
Other Persons/Agents Authorized to Access to Patient Records & Billing Information

_____
Signature of Patient or Person with Authorizing Consent

_____
Relationship to patient

OFFICE POLICIES AND PROCEDURES

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(INIT)_____**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. If incorrect insurance information is given that requires a claim to be re-filed, there will be a $35 re-filing fee.

- (INIT)_____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.
- (INIT)_____The following circumstance may result in you being billed directly.
    - We are not a participating physician 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 your insurance plan that mean insurance will not cover some or all of the visit
- (INIT)_____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.

- (INIT)_____High Deductible Insurance Plans**:** If you have a high deductible insurance plan, it could be the case that it may not cover basic office visits, if this is the case, we will charge 80% of allowable visit charge at the time of the visit as the visit may not be covered by your insurance. 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 an immediate 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 they have the appropriate insurance cover for the visit and services, if you are not sure, please call your insurance company before the visit.

(INIT)_____**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.

(INIT)_____**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.

(INIT)_____**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.

(INIT)_____**REFERRALS:** Referrals may be needed for specialists, emergency room visit, urgent care visits, 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.

(INIT)_____**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.

(INIT)_____VIDEO & CAMERA POLICY**:** No photos or Videos are allowed in the office.

(INIT)_____LETTERS AND FORMS RQUESTS: There will be charge of $25 for letters and $40 for form filled out on the patients request by the Practice/Doctor payable on check out.

(INIT)_____LATE ARRIVALS: Patients that arrive more than 15 minutes late for appointments will have appointments rescheduled as the discretion of the practice.

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

Print name _____

Signature_____ Date_____

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CONSENT TO RELEASE MEDICAL RECORDS

I, _____, Date Of Birth _____/_____/_____, Hereby authorize, to have bilateral exchange of information that is contained in my medical record with:

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Under the conditions listed below:

1. This information will be limited to:

   _____ Medical evaluation
   _____Billing, Insurance, & Related Information
   _____Medical Test / Studies
   _____Other:

2. Purpose or need for such disclosure: _____

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not preciously revoked, this consent will terminate upon_____.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
SIGNATURE OF PARENT, GAURDIAN OR ANOTHER PERSON DATE
Authorized by law to sign in lieu of Patient
(Where required). Indicate which.

_____ _____
NOTARIZED DATE