Sarcena Medical Group, PLLC

REGISTRATION FORM

(Please Print)

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

Pharmacy Name: Pharmacy Phone Number:

INSURANCE INFORMATION

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ [Insurance] ☐ Welfare *(Please provide coupon)* ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: / / Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Patient Name: _____

Sarcena Medical Group, PLLC

Past Medical History

Please check any past medical conditions:

☐ Kidney Disease ☐ Diabetes (Type1 or 2) ☐ Cancer (Type: _____)

☐ High Blood Pressure ☐ Ischemic Heart Disease ☐ Stroke

☐ Gout ☐ Other: _____

Surgical History

Please list any prior surgeries (including year, if known): ☐ None

_____

_____

_____

Family History

Condition	Father	Mother	Sibling	Child	None
Kidney Disease					
Diabetes					
High Blood Pressure					
Ischemic Heart Disease					
Cancer					
Stroke					
Gout					
Polycystic Kidney Disease					
Dementia					

Father:

☐ Living ☐ Deceased ☐ Unknown

Age of Death: _____

Cause of Death: _____

Patient Name: _____

Mother:

☐ Living ☐ Deceased ☐ Unknown

Age of Death: _____

Cause of Death: _____

Social History

Current Marital Status:

☐ Married ☐ Single ☐ Divorced

☐ Separated ☐ Widowed

Living Arrangement:

☐ Alone ☐ Spouse ☐ Significant Other

☐ Family Member ☐ In home Caregiver ☐ Assisted Living Facility

Occupation:

☐ Retired ☐ Employed ☐ Unemployed

☐ Student ☐ Disabled

Current/Former Occupation: _____

Functional/ Cognitive:

☐ No impairment ☐ Memory Deficit ☐ Hearing Loss

☐ Poor Vision or Blindness ☐ Limited Mobility ☐ Transportation Challenges

Tobacco Use:

☐ Current User ☐ Former User ☐ Never Used

Type:

☐ Cigarettes ☐ Chewing Tobacco ☐ Cigars

☐ Snuff ☐ Pipes

Frequency:

☐ Every Day ☐ Some Days ☐ Unknown

Packs Per Day: _____ Years Smoked: _____

Date Started: _____ Date Quit: _____

Cessation Counseling Provided: _____

Patient Name: _____

Cessation Methods and Strategies Discussed: _____

Cessation Medication Prescribed: _____

Alcohol Use:

☐ Current User ☐ Former User ☐ Never Used

Amount:

☐ Social Drinker ☐ 1-2 drinks/day ☐ 3+ drinks/day

Date Quit: _____

Recreational Drug Use:

☐ Current User ☐ Former User ☐ Never Used

Type:

☐ Marijuana ☐ Heroin ☐ Cocaine

☐ Amphetamines ☐ Ecstasy ☐ Barbiturates

☐ LSD ☐ Opium ☐ Other

Date Quit: _____

Tattoos:

☐ Yes ☐ No

Blood Transfusion:

☐ Yes ☐ No ☐ If so, when: _____

Exercise:

☐ Yes ☐ No ☐ Frequency: _____

Caffeine Use:

☐ Yes ☐ No ☐ How Often: _____

NSAID (Ibuprofen, Aspirin, Naproxen Sodium) Use:

☐ Yes ☐ No ☐ Frequency: _____

For Women: Last Menstrual Cycle: _____ Last Mammogram: _____

Patient Name: _____

Review of Systems

Constitutional:

- ☐ Fever
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Chills
- ☐ Weakness
- ☐ None of the above

HEENT:

- ☐ Vision Impaired
- ☐ Sinus Problems
- ☐ Eye Pain
- ☐ Sore Throat
- ☐ Redness
- ☐ Nose Bleeds
- ☐ Color Blindness
- ☐ Headache
- ☐ Double Vision
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Ear Pain
- ☐ Vertigo
- ☐ None of the above

Respiratory:

- ☐ Shortness of breath
- ☐ Cough
- ☐ Shortness of breath at rest
- ☐ Blood in sputum
- ☐ Night Sweats
- ☐ Shortness of breath with activity
- ☐ Pain with breathing
- ☐ Wheezing
- ☐ None of the above

Cardiovascular:

- ☐ Chest Pain
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Claudication
- ☐ Edema
- ☐ PND
- ☐ None of the above

Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Nausea
- ☐ Anorexia
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Indigestion
- ☐ Trouble Swallowing
- ☐ None of the above

Genitourinary:

- ☐ Urinary Urgency
- ☐ Urinary Hesitancy
- ☐ Urinary Burning or Pain
- ☐ Foamy Urine
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Urinary Frequency
- ☐ Nocturia
- ☐ None of the above

Musculoskeletal:

- ☐ Back Pain
- ☐ Muscle Pain
- ☐ Neck Pain
- ☐ Arm Weakness
- ☐ Leg Weakness
- ☐ Joint Pain
- ☐ None of the above

Patient Name: _____

Skin:

☐ Itching ☐ Dryness ☐ Color Change
☐ Scaling ☐ None of the above

Neurological:

☐ Numbness ☐ Tingling ☐ Tremors
☐ Fainting ☐ Seizures ☐ None of the above

Psychiatric:

☐ Depression ☐ Anxiety ☐ Insomnia
☐ None of the above

Endocrine:

☐ Heat Intolerance ☐ Excessive Thirst ☐ Cold Intolerance
☐ None of the above

Hematology:

☐ Bleeding Gums ☐ Easy Bruising ☐ None of the above

Immuno/Allergy:

☐ Seasonal Allergies ☐ Hives ☐ None of the above

Notes: _____

_____

I certify that the information disclosed is correct to the best of my knowledge. I will not hold Sarcena Medical Group, PLLC. responsible for any errors of omission that I may have made in completion of this form.

Printed Name: _____ Date: _____

Signature: _____

SARCENA Medical Group, PLLC
MEDICATION POLICY

Patients are required to see their physician in order to receive a prescription for controlled medications (narcotics, muscle relaxants, sedatives, or anti-anxiety medications). No refills will be authorized by fax or phone. Prescriptions will not be available for pick-up without seeing the physician.

The patient is responsible for scheduling appointments in a timely manner to avoid running out of medication. Please note that the patient risks possible symptoms of withdrawal if he/she fails to schedule the follow-up appointment. Please call at least one week in advance to schedule your follow-up appointment.

Long term use of controlled medications can cause physiological and/or psychological dependence. Therefore, compliance with medication usage is monitored and if any abuse is determined, the patient will be expeditiously weaned off the medication and referred to a substance abuse program.

Patients receiving controlled medications (narcotics, muscle relaxants, sedatives, or anti-anxiety medications) are responsible for the care of the medications. Any lost, stolen or mishandled medications will be refilled on a case by case basis. The patient must provide our office with a detailed police report if any medication is stolen. If a medication is lost, a notarized letter from the patient stating the details of the loss must be provided to the office. Frequent mishandling of medications will result in non-refill of the prescription. Issuing a refill will be to the discretion of the physician.

Patients prescribed controlled medications may be asked to perform a random drug screen test. Refusal to cooperate with this testing will result in non-refill of medications.

If a patient is receiving controlled medications from our office, it is our policy that patient may not receive controlled medications from another physician unless prior arrangements are made, and documented, with our physician. **Deviation of this policy may result in the termination of treatment by this office.** This is for the patient's safety and well-being.

Take medications only as prescribed. If the prescribed medication is not effective in controlling your symptoms, call your physician first. **Never take more medication than prescribed unless the physician instructs you to do so.** No early refills will be given if the medication does is altered without prior authorization from your physician.

By signing, I am stating I have read and fully understand this physician-patient contract:

Print Patient Name	Signature of Patient/Guardian	Date

Sarceana Medical Group, PLLC

Privacy Practices Acknowledgement

I acknowledge receipt of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

_____ _____

Patient/Guarantor Signature Date

Consent for Treatment

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment of examination at **Sarceana Medical Group**, PLLC.

_____ _____

Patient/Guarantor Signature Date

Consent to Medical Treatment by Physician Assistant or Nurse Practitioner

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment of examination at **Sarceana Medical Group** PLLC.

_____ _____

Patient/Guarantor Signature Date

Sarcena Medical Group

Authorization for Release of Health Information Pursuant to HIPAA

Patient Name (please print)	Date of Birth	Last 4 of Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with Texas State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT (except psychotherapy notes), and CONFIDENTIAL HIV-RELATED INFORMATION only if I place my initials on the appropriate line in Item 9. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9, I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the Region VI Office for Civil Rights in the U.S. Department of Health and Human Services at (214)767-4056. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE DISCUSSION OF MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE INDIVIDUAL(S) IN ITEM 8.**

7. ***Name and address of health provider or entity to release this information:*** Sarcena Medical Group, 2525 North Loop West, Suite 600, Houston, TX 77008 713-866-6201

8. ***Name of person(s) to whom my protected health information may be provided or with whom my protected health information may be discussed, including care and treatment (please limit to three):***

9. ***Specific information to be released:***

☐ Medical records from (insert date) _____ to (insert date) _____ or ☐ All Dates

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, medication information, and records sent to you by other health care providers.

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

10. ***Date or event on which this authorization will expire:***

11. ***If not the patient, printed name of person signing this form:***

12. ***Authority to sign on behalf of patient:***

All items of this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: _____

Signature of patient or representative authorized by law.

Sarcena Medical Group, PLLC

FINANCIAL POLICY

We are pleased to inform you that we participate in a contract with your managed care plan. Under your plan we have agreed to file your insurance claim on your behalf, accept a discount off our standard fee, and collect your out of pocket expenses. In order for us to continue to provide services at a discounted fee, it is necessary for us to reduce our billing expenses. Therefore, your out-of-pocket expenses must be paid in full on the day office services are rendered. Out of Pocket expenses include your co-payments, deductibles, and coinsurances(e.g. if your plan pays 80% we will collect your co-payment, deductible and 20% of the balance). Health insurance contracting requires patient co-payments to be paid at the time of service and does not permit patient financial responsibility to be waived. We will estimate your out of pocket expenses as closely as possible based on the individual fee schedule provided by your insurance company. If your insurance company has not provided their fee schedule to us we will estimate a discount based on the average discount of all our managed care contracts.

For covered services, we will file a claim for each service with our standard charge to your insurance company. Claims may be filed to up to 2 separate insurance companies to those patients who have primary and secondary insurance. During the time your insurance company is processing your claim you may receive informational statements from us. However, unless your statement reflects an amount due, no payment is required at that time. If your insurance company sends you a form to complete, requesting additional information from you, no prompt response is necessary. We suggest you send this information to your insurance company by certified mail, return receipt. In the event your insurance company does not receive this information, you will be responsible for payment of our full charges and no discount will be applied.

Although every effort will be made to estimate your actual out of pocket expenses, your insurance company may process your claim differently than what will originally estimated. After your charges are fully processed by your insurance company(s) and all payments and discounts are applied we will send you notification by mail of any further balance due. Any balance that is your responsibility after insurance is processed is due within 30 days. If extended payments are needed on large balances our patient account representatives are available to discuss payment plan options with you. If you discover an error on your bill or need additional information, please contact the patient account representative at 713-795-5511. We will refund any overpayment due to you within 30 days provided no other claims are outstanding.

MEDICARE:

If you do not have secondary insurance, you will be responsible for paying your unmet deductible and any co-payment Medicare requires you to pay at the time services are rendered. These amounts are called co-insurance. The Medicare program has expanded coverage in recent years; however, it may not cover some preventive services. In this event you will be asked to sign a waiver and pay in full for any non-covered services at the time those services are rendered. Please remember that you may receive separate bills for any hospital services, lab work, radiological testing, dialysis, or other services provided outside of this office from the other providers or facilities.

REFERRALS/AUTHORIZATIONS:

If your insurance company requires that you obtain a referral/authorization prior to being seen, all such documentation is your responsibility. Your cooperation is necessary in obtaining the proper referral/authorization. Please be advised that if you elect to be seen without a valid referral/authorization or you have changed Primary Care Provider without obtaining a new referral/authorization or your referral/authorization is expired your services will be considered non covered and you will be responsible for payment of our full charges and no discount will be applied. If out-of-network benefits are available under your policy the portion you are responsible for paying will be higher than if a referral/authorization was obtained. Please be advised that the referral/authorization you obtained to be treated by your doctor here at Sarcena Medical Group, PLLC will not cover your services rendered outside of this office. You must obtain separate referral/authorization and you will receive separate bills for any services rendered outside of this office by the providers of those services, (e.g. lab work, radiological testing, neurological testing, anesthesia, or other services).

DIALYSIS SERVICES AND HOSPITAL SERVICES:

Services by Sarcena Medical Group, PLLC will consist of separate charges for 1) office visit, 2) inpatient and outpatient hospital services and 3) dialysis services. Although services may be provided to you outside the Clinic, referrals and authorizations may be required and payment responsibilities still apply. In this event, you will receive a bill for the portion of any deductibles you are responsible to pay under your policy after the managed care discount is applied.

PRE-EXISTING CLAUSES

Your insurance plan's guidelines may include a pre-existing clause, which states that your insurance company will not pay for treatment of certain conditions that have been previously treated up to a specified length of time prior to your effective date of coverage. If your policy includes a pre-existing clause, and your insurance company subsequently investigates your claim and determines your services to be non covered you will be responsible for payment in full within 30 days and no discount will be applied.

RETURNED CHECKS/NSF CHECKS:

There is an fee of $25.00 for returned checks. This fee, plus the amount of the check, will be posted to your account and is immediately due.

Please read this policy carefully. If you have any questions regarding our policy, please ask to speak with our business office. Your signature on this page constitutes an agreement to this policy and the authorizations below.

I, _____ authorize the release of any medical or other information necessary to process my claim(s). I also authorize payment of insurance medical benefits to Sarcena Medical Group, PLLC for all outstanding services rendered to me. I certify that I have read and understand this policy.

X _____ _____

Signature of Patient/Responsible Person on Account Date

Deborah McCoy, M.D.
2525 North Loop West, Suite 600,
Houston, TX 77008
Phone: 346-867-6630
Fax: 346-867-6631

SARCENA
Medical Group

I,_____,authorize_____ to

Release medical record information which may include, but is not limited to, communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), psychiatry, drug, and/or alcohol abuse for the following patient:

Patient Name: _____Date of Birth: _____

PLEASE RELEASE INFORMATION TO:

Sarcena Medical Group, PLLC
2525 North Loop West, Suite 600
Houston, TX 77008

Purpose: ☐v Continuation of Care ☐ Other

_____

I understand that this authorization shall remain in effect for one year or until expressly revoked by me. I understand that I may withdraw this authorization by submitting a written, dated request to revoke. Such revocation does not affect actions that have already been taken based on this authorization.

Patient Signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____

Relationship: _____ Date: _____