Office Use Only - Account Number:_____ Revised 4/26/2018

Sammy Lerma III, M.D. P.A.

History and Physical

Name:	**DOB:**	**Age:**
Reason for Visit:	**Last Physician's Name:**	
Surgery history **(year, type):** _____ _____ _____	***Current Medications***- List below or provide list at Check-in: Name, Strength, Instructions: _____ _____ _____	
Medication Allergies:		
Have you ever been diagnosed with any of the below conditions?		
☐ADD/ADHD ☐Alcoholism ☐Arthritis ☐Asthma	☐Cancer (Type:): _____ ☐Depression/Anxiety ☐Diabetes	☐Drug Addiction ☐Heart Disease ☐High Blood Pressure ☐ High Cholesterol ☐Kidney Disease	☐Migraines ☐Sexual Dysfunction ☐Stroke ☐Other: (List) _____
Do you drink? ☐Yes ☐No. If yes, how much?		Do you take illegal drugs? ☐Yes ☐No	
Do you smoke? ☐Yes ☐No If yes, how much? _____ How long have you smoked? _____		Are your immunizations current? ☐Yes☐No If under 18, please provide a copy for our records..	
Preventative Care is very important. Please list your most recent care by Month and Year.			
☐ Physical exam When?	☐Chest x-ray When?	☐Rectal exam When?	☐EKG When?
☐Bone density When?	☐Vaginal Exam/PAP When?	☐Colonoscopy When?	☐Mammogram When?
☐Routine lab When?	☐Flu Shot When?	☐Tetanus Shot When?	☐TB Test When?
☐Cholesterol Test When?	☐Testicular Exam When?	☐Prostate Exam When?	☐Breast Exam When?
Please check your family's medical history. **Note Mother (M), Father (F), Sibling (S), Paternal Grandparent (PG), or Maternal Grandparent (MG).**			
Heart Disease:	Diabetes:	High Blood Pressure:	Stroke:
Kidney Disease:	Alcohol Abuse:	Drug Abuse:	Cancer (Type):
Other:	Father's age at time of death: Cause of death:		
Mother's age at time of death: Cause of death:		Sibling's age at time of death: Cause of death:	
Do you have advance directives? ☐Yes ☐No .If yes, please provide a copy for your chart.			
Patient Signature:			**Date:**
Medical Staff Signature:			Review Date:

Office Use Only - Account Number:_____ Revised 3/2018

Sammy Lerma III, M.D. P.A. - Office Policies

Nurse Practitioners - Our office has Nurse Practitioners on staff to assist in the delivery of medical care. A Nurse Practitioner is not a doctor, but is a registered nurse with advanced training in the provision of healthcare. They can diagnose, treat, and monitor common, acute, and chronic diseases as well as provide health maintenance care. Medical supervision does not require the constant physical presence of the supervising physician, but rather the overseeing of the activities and accepting the responsibility for the medical services provided. I understand that at any time, I can refuse to see the Nurse Practitioners and request to see the physician. Please make this request when scheduling your appointments.

Patient-Physician Relationship - Please be advised that an initial visit for evaluation purposes does not guarantee entry to our practice, and does not automatically create an ongoing patient-physician relationship.

Medication Refills - Please schedule an appointment to see a provider **1 month** before you run out of medication. ***For all early refills, please submit a refill request through your pharmacy***. Controlled substance medications will never be refilled or prescribed by phone or pharmacy request; they require an appointment **monthly** for refills and are subject to regular drug testing. Maintenance medications (i.e. blood pressure medications, diabetic supplies, heart medications, etc.) will require an appointment every **3 months** for refills. We do not prescribe pain medications on an ongoing basis. If you have chronic pain issues, we will determine an appropriate referral to meet your pain management needs.

Appointments

If you need an appointment, please call in advance. We do not offer walk-in appointments, but we will make every effort to see you as soon as possible. Please inform us of any changes to your address, phone numbers, email address, insurance, pharmacy of choice, and emergency contact information when scheduling your appointment. Please bring an updated list of all of your current medications to each appointment.

New patients will be required to arrive 15 minutes before your scheduled appointment time to complete new patient paperwork. You must bring a valid photo ID, your insurance card (if you have insurance), and a list of current medications. Patients with digital copies of their insurance can bring a copy of their card and/or request to email a copy of the card.

All out of pocket expenses (co-pays, deductibles, private pay office charges) are due in full at time of visit.

No Call/No Show & Late Policy NOTICE

Due to high demand and limited availability of appointments, we require at least a **24-hour notice** of a cancelled appointment - emergency situations notwithstanding. We allow up to 3 missed no show, cancelled, or rescheduled appointments without proper notice per calendar year; after that your account will be forwarded to our management staff for review.

Please note that if you are 10 minutes late for your scheduled appointment time, your appointment will be rescheduled.

Lab Results - Our medical providers will review your lab results as soon as they have been received. You will ONLY be contacted if your lab results require additional care and/or treatment.

Terms of Service

I have read and agree to the terms listed in the *Consent for Treatment*, *Financial Policies, HIPAA Compliance Patient Consent Form*, and the *HIPAA Notice of Privacy Practices* and understand that I can request a copy of these forms for my record at any time from the front desk receptionist.

PRINT Patient Name_____ DOB_____
Signature of Patient or/Guardian _____ Date_____
Relationship to Patient (Self, mom, dad, care provider, etc.)_____

Office Use Only: Please list all of the preventative care for this patient.			
☐ Physical Exam	☐ Chest X-Ray	☐ Rectal Exam	☐ EKG
☐ Bone Density	☐ Vaginal Exam/Pap	☐ Colonoscopy	☐ Mammogram
☐ Routine Lab	☐ Flu Shot	☐ Tetanus Shot	☐ TB Exam
☐ Cholesterol Test	☐ Testicular Exam	☐ Prostate Exam	☐ Breast Exam
RTC for Prevention: ☐ Week ☐ Month ☐ Year			

Office Use Only - Account Number:_____ Revised 2/2018

Sammy Lerma III, M.D. P.A.
Consent for Treatment

Name:	**Address:**	**Phone #:**
Email address:	**Pharmacy of Choice:**	**Emergency contact (name & phone number:**

Insurance Coverage	☐ **NONE**	☐ **YES - NAME OF COMPANY:** **PROVIDE COPY OF CARD**

Medical Consent - I consent to treatment given under the general and special instructions of the attending physician and nurse practitioner(s). Treatment may include, but is not limited to, diagnostic procedures, use of prescribed medication, medical services, the collection and utilization of cultures and laboratory specimens, and referral to specialty services for radiology, physician consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physician/nurse practitioner.

Assignment of Benefits

I understand that I am financially responsible for payment of all services rendered.

I hereby authorize Sammy Lerma III MD PA to bill my insurance carrier or other payment source, if any.

I assign all benefits and authorize payment directly to Sammy Lerma III MD PA for any benefits otherwise payable to me for all claims for such services provided or submitted prior to, or after the date provided on this form.

I understand that I am obligated to pay all charges not covered by insurance, Medicare, Medicaid, or other benefits. This agreement and authorization of benefits in no way releases me from said responsibility and imposes no obligation on Sammy Lerma III MD PA to collect money on my behalf.

I warrant and represent that any insurance/plan that I assign is valid insurance and in effect, and that I have the right to make this assignment.

In the event that a claim submitted for payment is denied, I authorize Sammy Lerma III MD PA to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan/policy.

I appoint Sammy Lerma III MD PA to collect the claims, endorse the payment, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, the payment will be posted to the intended account and either a credit will be given to the account or a refund will be processed accordingly.

I acknowledge and agree that Sammy Lerma III MD PA and any affiliates or vendors thereof, including collection or billing companies, may contact me by telephone at any telephone number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as a dialing service or prerecorded message. I also agree that I will notify Sammy Lerma III MD PA if I have given up ownership or control of any such telephone number.

Medicare Patients - Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Sammy Lerma III MD PA on my behalf. I certify that the information given by me is correct.

Disclosure/Use of Health Information - I authorize Sammy Lerma III MD PA to provide any health information to my insurance company or other payor, for purposes of payment for the healthcare provided. I also authorize the release of my health information to other physicians and healthcare facilities for continuing care. I further agree that my health information can be used for operations such as peer review and analysis. I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices.

I acknowledge that my agreements hereunder are with and for the benefit of each entity and provider doing business as part of the offices of Sammy Lerma III MD PA and may be enforced under the practice name or provider name.

PRINT Patient Name_____ DOB_____
Signature of Patient or/Guardian _____ Date_____
Relationship to Patient (Self, mom, dad, care provider,etc.)_____

Office Use Only - Account Number:_____ Revised 3/2018

Sammy Lerma III, M.D. P.A.
Financial Policies

Our primary goal is to provide excellent health care to all of our patients. It is necessary, however, to establish policies to avoid misunderstandings. We would like to clarify the following policies that are followed by our practice.

Payment for Services - **All out of pocket expenses (co-pays, deductibles, private pay office charges) are due in full at time of visit.** You may pay with cash, personal check, certain credit cards, or debit card. If you cannot pay, you will have to reschedule your appointment. Our office does not offer payment plans.

Insurance Coverage - We accept many, but not all insurance plans. Your insurance is a contract between you and your insurance plan. Therefore, it is your responsibility to know whether our providers participate with your insurance. To find out whether your doctor is participating with your specific insurance plan, please call them directly or refer to your provider directory. Our office will attempt to verify your benefits prior to your appointment, but knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions about your coverage or claims processing. NOTE: If you have insurance, but we are unable to verify your benefits, your appointment must be rescheduled until benefits can be verified, unless you choose to pay the private pay rates.

Proof of Insurance - All patients must complete our patient information before seeing the doctor. We must obtain a copy of your driver's license and current, valid proof of insurance. If you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the charges incurred. If any information changes, you must notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Co-payments, Deductibles, Additional Services, Private Pay, and Balances - It is our desire to meet our patients' medical needs. Charges for services are based on the number of concerns a patient has, as well as the complexity of the patient's diagnosis. Co-payments are due at the time of Check-in; this arrangement is part of the patient-insurance company contract. Private pay rates are also due at the time of Check-in. Deductibles, coinsurance, and additional service charges are due at the time of Check-out. Patients are responsible for paying outstanding account balances from previous services provided; if you are unable to pay for those services while in the office for the current day visit, you should complete a form authorizing our office to collect the payment via credit card on a designated date. Patients who habitually fail to pay for services provided are subject to disciplinary action, up to and including termination of the physician-patient relationship.

Returned Checks - A $30.00 service charge will be added for all checks that are returned to us for insufficient funds. If payment is not received within 10 days of notification, the returned check will be reported to the District Attorney's Office, and you will be responsible for all incurred fees and the total balance of the service without the initial prompt pay discount (PPD).

Referrals/Authorizations - It is your responsibility to obtain valid authorizations from your primary care physician (PCP) if your insurance company requires them. Authorizations must be provided by your insurance plan to our office prior to your appointment. If our office does not have your authorization, your appointment will be rescheduled or appropriate payment will be required at the time of your appointment.

Work Related Injuries - You must tell our office if your injury/condition is work-related. You should bring a First Report of Injury form to your appointment; you will only be treated for the injuries approved on this form. If you work for an employer who is covered under provisions of the Texas Workers' Compensation Act, any injury/condition caused while performing services for the employer must be filed under Workers' Compensation according to Texas law.

Completion of Medical Forms and Copies of Medical Records

There may be a charge for completion of forms such as disability, camp physicals, etc.

In addition, state/federal laws allow charges for release of medical record copies. You will be provided an estimate of the charges prior to copies being made. Payment may be required before release of records.

Payment for Services Provided by Certain Non-Staff Providers - If you are having laboratory and/or diagnostic services ordered outside of our office, you may be billed separately by that service provider.

Collection Policy - If any balance is outstanding, we may refer your account to a collection agency, and you might be discharged from this practice. If this office must take action to collect an outstanding balance on your account, you will be responsible for payment of all costs of such collection efforts (e.g. certified mail costs and collection agency fees).

I have read and understand the financial policies and agree to abide by all guidelines.

PRINT Patient Name_____ DOB_____

Signature of Patient or/Guardian _____ Date_____

Relationship to Patient (Self, mom, dad, care provider, etc.)_____

Office Use Only - Account Number:_____ Revised 2/2018

Sammy Lerma III, M.D. P.A.

HIPAA Compliance Patient Consent Form

Our *HIPAA Notice of Privacy Practices* provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You agree by your signature that you have received our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you voluntarily consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, you understand that:

- Protected health information will be disclosed or used for treatment, payment, or healthcare provisions.
- Our practice reserves the right to change the privacy policy as required by law.
- Our practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will cease.
- Our practice may contact you for scheduling purposes, appointment reminders, payment reasons, or other aspects of your care. Unless you give written notification otherwise, we will leave a message on your answering machine/voice message or with someone who answers your phone, if you are not available.

FOR PATIENT COMPLETION:

May we discuss your medical condition with any member of your family or another individual? ☐ Yes ☐ No
IF YES, please name the individuals allowed:

Name:	Date of Birth:	Relationship:	Phone #:
Name:	Date of Birth:	Relationship:	Phone #:
Name:	Date of Birth	Relationship:	Phone #:

Check the box of the information to be released:

☐ **All medical records** (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing/insurance records, and records received from other healthcare providers)

OR:
☐ Medical record from _____ (date) to _____ (date) (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing/insurance records, and records received from other healthcare providers)

CHECK WHICH SPECIAL INFORMATION YOU WANT TO RELEASE:

☐ Drug, alcohol or substance abuse records	☐ Mental Health records (except psychotherapy notes)	☐ HIV/AID-related information (including HIV/AIDS test results)	☐ Genetic information (including genetic test results)

PRINT Patient Name_____ DOB_____
Signature of Patient or/Guardian _____ Date_____
Relationship to Patient (Self, mom, dad, care provider, etc.)_____

Office Witness Signature: _____ Date: _____