

Anastasia Medical Group

Anil Shrestha, M.D. Board Certified in Endocrinology & Internal Medicine

Suhas Neerukonda, M.D. Board Certified in Internal Medicine

Ryan Pereira, D.P.M. Board Certified- Foot & Reconstructive Rear Foot/ Ankle Surgery

Dear Prospective Patient:

We respect your time and would like to make your visit as efficient as possible. Please make sure you arrive fifteen minutes prior to your appointment time for check in. To avoid delays when you arrive, **please complete the enclosed forms in advance then fax 904-461-0823 or bring them with you to our office.**

Please Note: We reserve the right to reschedule your appointment if the paperwork is not completed in advance.

Our office policy is that we collect co-pays, co-insurance and deductibles at the time of service. Please bring the following paperwork with you at the time of your appointment:

- Your picture ID and Insurance cards.
- Completed patient demographics attached with this letter.
- A list of current medications.
- Any X-ray or reports if applicable
- If diabetic, Glucose Meter and Log Book

Our office is located at:

1301 Plantation Island Dr. S.
Suite 203
St Augustine, FL 32080

If you have any question please call our office at 904-461-0821

Thank you,

Anastasia Medical Group

*1301 Plantation Island Drive, Suite 203A, Saint Augustine, FL 32080
Tel: 904 461 0343/0821, Fax: 904 461 0823*

ANASTASIA MEDICAL GROUP

PATIENT INFORMATION FORM

NAME: _____
(Last) (First) (MI)

SS# _____ DATE OF BIRTH ____/____/____ AGE _____

SEX: M F MARITAL STATUS: Single Widowed Married Divorced

MAILING ADDRESS _____
(Street) (City) (State) (Zip)

HOME ADDRESS _____

TELEPHONE: Home _____ Work _____ Cell _____

EMAIL: _____

PREFERRED METHOD OF COMMUNICATION: Home Work Cell Text Email

PRIMARY PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

RACE: White Black/ African American Native American/ Alaska Native Asian Hawaiian/ Pacific Islander Hispanic/ Latino Other: _____

ETHNICITY: Hispanic/Latino Non-Hispanic/Non-Latino

PRIMARY LANGUAGE: English Spanish Other: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____

TELEPHONE: Home _____ Work _____ Cell _____

RESPONSIBLE PARTY INFORMATION:

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF RESPONSIBLE PARTY: _____

RESPONSIBLE PARTY ADDRESS (IF DIFFERENT FROM ABOVE): _____

INSURANCE INFORMATION

Primary insurance: _____	Secondary Insurance: _____
Primary Insurance ID #: _____	Secondary Insurance ID #: _____
Primary Insurance Group #: _____	Secondary Insurance Group #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
DOB of Policy Holder: _____	DOB of Policy Holder: _____
Relationship to Patient: _____	Relationship to Patient: _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN AND RELEASE INFORMATION:

I hereby authorize the release of any medical information necessary for the processing of insurance claims. I also assign all medical benefits to include major medical benefits to which I am entitled to ANASTASIA MEDICAL GROUP. This assignment will remain in effect until revoked by me in writing. Furthermore, a photocopy of this assignment is to be considered as valid as the original.

I further agree to be solely responsible for any balances that my insurance carrier does not pay.
In signing this form I am authorizing you to give me reasonable and proper medical care by today's standards.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____

NAME: _____ DATE: _____

**ANASTASIA MEDICAL GROUP
PATIENT HISTORY**

Name: _____

Date: _____

Medical concern which brings you to our office: _____

Personal History:

	Alive Y/N	Medical Problems	Habits:
Father			Smoking: no / yes / ready to quit; if yes _____ packs per day _____ years
Mother			Caffeine (coffee/ tea/ cola): no / yes; if yes _____ drinks/day
Brother			Alcohol: no / yes; if yes _____ drinks/day
Sister			Other substance usage: no / yes; if yes, details _____
Other Family Member			

Allergies/Intolerances to medicines, foods, or environmental factors:

Name:	Type of reaction	Name:	Type of reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Current Medications (include over the counter medications and natural remedies):

<u>Name</u>	<u>Dose & frequency</u>	<u>Date started</u>	<u>Name</u>	<u>Dose & frequency</u>	<u>Date started</u>
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

Pharmacy and phone number: _____

Past Surgery History: No / Yes; if yes please provide details:

<u>What</u>	<u>When (year)</u>	<u>Where</u>	<u>Surgeon</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Additional past outpatient medical history including hospitalization history: Negative / Positive; if positive, please provide details:

<u>What</u>	<u>When (year)</u>	<u>Where</u>	<u>Attending Physician's Name</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Do we have your consent to discuss your care with any person? No / Yes; if yes, who: _____

I want to be called with all test results even if normal. No / Yes

I want to be called with only abnormal test results and normal results to be discussed with me during my next doctor visit. No / Yes

Please list below the names and addresses of any physicians or hospitals that we can obtain past medical records from:

1. Name _____	2. Name _____	3. Name _____
Address _____	Address _____	Address _____
Phone no. _____	Phone no. _____	Phone no. _____

***NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

SIGNATURE: _____

I authorize, until further notice, that any of my medical records may be released to any physician that I am referred to and I authorize that any of my medical records be released, on a continuing basis, to my chiropractor, dentist, optometrist, audiologist, psychologist, that I am seeing, unless specified otherwise. Unless you indicate otherwise, a letter regarding your office visits will be sent to your house.

(Signature and Date)

ANASTASIA MEDICAL GROUP

**AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN
AND RELEASE OF INFORMATION**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me including HIV / AIDS, Psychiatric or substance Abuse Treatment, to release to the Health Care Financial Administration or its intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medicare/insurance benefits be made on my behalf to Anastasia Medical Group, LLC, for any services furnished to me by the physician.

I REQUEST THAT THIS APPLY TO ANY INSURANCE I MAY HAVE.

Signed _____ Date _____

By _____

Title or Relationship _____

If signed by other than beneficiary, state the reason the patient was unable to sign: _____

**AUTHORIZATION FOR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

1. PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ SSN #: _____ ADDRESS: _____ _____ TELEPHONE #: _____
2. TYPE OF RELEASE AUTHORIZATION PHYSICIAN INFORMATION	<input type="checkbox"/> I AUTHORIZE ANASTASIA MEDICAL GROUP TO RELEASE MEDICAL RECORDS INFORMATION TO: <input type="checkbox"/> I AUTHORIZE ANASTASIA MEDICAL GROUP TO OBTAIN MEDICAL RECORDS INFORMATION ON ME FROM: NAME OF PHYSICIAN: _____ ADDRESS: _____ _____ PHONE #: _____ FAX #: _____
3. PURPOSE FOR REQUEST	<input type="checkbox"/> CONTINUITY OF CARE <input type="checkbox"/> ATTORNEY <input type="checkbox"/> PERSONAL <input type="checkbox"/> INSURANCE CLAIM <input type="checkbox"/> CHANGE OF INSURANCE <input type="checkbox"/> OTHER: _____
4. INFORMATION NEEDED (CHECK OFF ALL THAT APPLY)	<input type="checkbox"/> ALL <input type="checkbox"/> LABORATORY RESULTS <input type="checkbox"/> X-RAY REPORTS <input type="checkbox"/> HISTORY AND PHYSICAL <input type="checkbox"/> IMMUNIZATION RECORD <input type="checkbox"/> OTHER: _____

I specifically consent to release information relating to: (initial selection)

STD _____ HIV/AIDS _____ TB _____ Drug/Alcohol _____ Mental Health _____ WIC Eligibility _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____ I understand that if I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. I understand that I may inspect or copy the information to be used or disclosed in CFR 165,524.

REVOCAATION: I understand that I have the right to revoke this authorization any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy.

Patient's /Legal Representative Signature: _____ Date: _____

If signed by Legal Representative, relationship to patient: _____

Information may release to: _____

Social Security#: _____ **DOB:** _____

Acknowledgement of Receipt

I hereby acknowledge that I have received a Copy of Anastasia Medical Group Notice of Privacy Practices.

(Signature of patient or patient's representative)

Date _____

Printed name of patient/patient's representative: _____

Relationship to the patient: _____

Welcome to Anastasia Medical Group, LLC! The office of Dr. Neerukonda, Dr. Pereira, and Dr. Shrestha

Our goal is to provide you with quality state-of-the-art care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records and your financial responsibility at the time of service or prior any scheduled surgery. If you have any questions please feel free to ask a staff member.

Your Insurance Policy: It is the policy of Anastasia Medical Group to collect any applicable co-payment, co-insurance and/or deductible at the time of service or prior to surgery. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

At this time our office is a participating provider for most insurance plans and most major insurance networks. If we are not a participating provider for your insurance plan we will still file your insurance claim as a courtesy. However, you will ultimately be responsible for any fees.

If you are enrolled in a managed care insurance plan (HMO) you must obtain a referral from your Primary Care Physician (PCP) before your office visit. We will assist you in this process if applicable. Please be aware that without a referral from your PCP your visit may have to be rescheduled.

Pre-certification or authorization for a service is not a guarantee of benefits. Benefits are determined when your insurance company receives our claim. If no benefits are due you will be responsible for any balance pertaining to denied services. In certain situations there may be appeal rights for our office. If so we will attempt an appeal even without you requesting us to do so. If no appeal rights are available for our office you will be mailed a statement for the balance due. Please be aware that any appeal rights available to the patient will have to be handled by the patient.

If your insurance policy is new you may be subjected to a pre-existing conditioned waiting period. This does not apply to Medicare coverage. Any services not paid by your insurance company for this reason will be your responsibility.

Any fees we charge are for our services only. Any services provided outside our office will be billed separately by that provider. This would include laboratory, CT Scans, MRI Scans and surgery performed at the hospital or any other facility. Please speak directly with those providers regarding their fees.

Federal Law prohibits our office from writing off any balance due after your insurance company pays. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit.

Missed Appointments/Late Cancellations: For Dr. Shrestha and Dr. Pereira patients

Missed appointments represent a cost to us, to you and other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment for an office visit. We reserve the right to charge \$40.00 for a missed or late cancellation for an office visit. A fee of \$200.00 may be applied to a missed or late cancellation of an office procedure. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in a discharge from our practice. Our office understands that emergencies do arise, but please call our office to discuss this matter with a staff member.

REFUNDS: Overpayments will be refunded upon request to the responsible party within 30 days. Please keep this in mind that an overpayment from your insurance company is not a credit to you and cannot be refunded to you.

Medical Records: Upon request we will provide you with copies of your medical records. However, this can be time consuming, so we charge \$1.00 per page for first 25 pages and \$0.25 per page for additional pages, with a minimum of \$5.00. Your insurance company does not cover this fee. Please allow 7 business days for this request.

Your Account: You will be mailed a statement on a monthly basis for any balance due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement please do not hesitate to call our office. We will make an attempt to collect any prior balance at your office visit as well as any applicable co-payment/co-insurance and/ or deductible. Your account must be current prior to any scheduled appointments. If your account is past due then future services may be postponed. For your convenience our office accepts cash, checks, Visa and Mastercard. **There will be a \$35.00 charge for returned checks.**

CO-pay/Co-insurance/Deductible: It is our policy to collect your co-pay, co-insurance and deductible at the time services are rendered.

Seriously past due accounts those older than 120 days or those failing to honor agreed-upon terms- will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information your past due debt will be reported on your credit history. Additionally you will be dismissed from our practice for financial matters and will have to seek healthcare elsewhere.

Patient dismissal: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.

I hereby understand and agree to the financial policy of Anastasia Medical Group.

Patient Name: _____

Signature: _____ **Date** _____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-prescribe program. These include:

- **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history-** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification-** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Anastasia Medical Group, LLC can request and use your prescription medication history from other healthcare providers and/or third parties pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Anastasia Medical Group, LLC to enroll me in the E-prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient