# 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: ______________________________________________________

PERMISSION TO LEAVE A VOICE MESSAGE: ☐ YES ☐ NO

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 ____________________

**Do we have your consent to discuss your care with above person? No / Yes; if no, who**: ___________________________________

**RESPONSIBLE PARTY INFORMATION:**

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

______________________________________________________________________________________

### 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, LLC. 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: ________________________________

Updated 08/2016

## 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):**

| Name | Dose & frequency | Date started | Name | Dose & frequency | Date started |
|---|---|---|---|---|---|
| 1. ______________________ | _________ | ___________ | 6.____________________ | ________ | ___________ |
| 2. ______________________ | _________ | ___________ | 7.____________________ | ________ | ___________ |
| 3. ______________________ | _________ | ___________ | 8.____________________ | ________ | ___________ |
| 4. ______________________ | _________ | ___________ | 9.____________________ | ________ | ___________ |
| 5. ______________________ | _________ | ___________ | 10.____________________ | ________ | ___________ |

***Pharmacy and phone number***: ________________________________________________________________

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

| What | When (year) | Where | Surgeon |
|---|---|---|---|
| 1. ______________________ | _________________________ | __________________________ | _____________________________ |
| 2. ______________________ | _________________________ | __________________________ | _____________________________ |
| 3. ______________________ | _________________________ | __________________________ | _____________________________ |
| 4. ______________________ | _________________________ | __________________________ | _____________________________ |
| 5. ______________________ | _________________________ | __________________________ | _____________________________ |

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

| What | When (year) | Where | Attending Physician's Name |
|---|---|---|---|
| 1. ______________________ | _________________________ | _______________________ | ___________________________ |
| 2. ______________________ | _________________________ | _______________________ | ___________________________ |
| 3. ______________________ | _________________________ | _______________________ | ___________________________ |
| 4. ______________________ | _________________________ | _______________________ | ___________________________ |
| 5. ______________________ | _________________________ | _______________________ | ___________________________ |

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

***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)

Updated 08/2016

## 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: ___________________________________

_________________________________________________________________________________________

**ANASTASIA MEDICAL GROUP**
1301 PLANTATION ISLAND DRIVE SOUTH, SUITE 203A, ST. AUGUSTINE, FL32080
PHONE #: (904) 461-0821, Fax #: (904) 461-0823

# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

**REDISCLOSURE:** I understand that once the above information is disclosed, it may be re-disclosed 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 45 C.F.R. 164.524.

**REVOCATION:** I understand that I have the right to revoke this authorization any time. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. 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: ____________________

Patient's Social Security#: ____________________ DOB: ____________________

Updated 08/2016

# ANASTASIA MEDICAL GROUP

## FINANCIAL POLICY

**Welcome to Anastasia Medical Group, LLC! The office of Dr. Neerukonda, and Dr. Pereira,**
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:**
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. Contact Stephanie Feutz with billing questions at 904-461-0821.**

**Copay/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**___________________

Updated 08/2016

## ANASTASIA MEDICAL GROUP

### 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**

## ANASTASIA MEDICAL GROUP

### PATIENT PORTAL ACCESS

**Anastasia Medical Group**

is now offering its patients easy and private access to their medical

information online, so you can view your personal health record

whenever and wherever you have access to the Internet!

To gain access to our secure server on Patient Portal and become

web-enabled, simply sign-up by providing us with a personal

(Non-work) e-mail address. You will be able to securely login with your username and password

and gain access to your personal health record and other helpful

features from any computer or smartphone with an Internet

connection!

Write your e-mail address below and give it to any of our staff to start web access.

______________________________________________________________

NO EMAIL:_____________________________________________

Updated 08/2016

## Acknowledgement of Receipt

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

______________________________________________ Date_________________________

(Signature of patient or patient's representative)

Printed name of patient/patient's representative:____________________________________________

Relationship to the patient: ____________________________________________________________