Jorge A. Saldivar M.D., P.A.

CREDIT AND FINANCIAL POLICY. PLEASE READ AND SIGN BELOW.

We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this vital health care facility for our patients and community.

Payment for medical services at our office is expected at time services are rendered. If you have health insurance, please understand that this is an agreement between you and your insurance company and even though we might participate with your plan, it should be understood that you are responsible for your bill regardless of the status of your insurance claim and will require your full cooperation in ensuring that your bill in our office gets paid in a correct and timely manner. Any co-payments, co-insurances and deductibles are due at the time of service (in the case of surgical procedures, your portion due is payable before the date of the procedure, usually at the time of your pre-operative orders appointment and for pregnancy, a special plan will be worked out so that your portion is paid off before the delivery).
Our insurance personnel will help you in obtaining insurance plan benefits. Please advise us of any special provisions of your plan (i.e. specific laboratory requirements, pre-authorization of certain procedures, referrals, etc).

Except when hardship warrants otherwise, accounts 90 days past due will be reported to Experian Credit Bureau Services, at which time a $90.00 service charge will be added to your account balance. If you choose to allow this to happen, you will be dismissed as our patient and you will be referred to other medical facilities for your care. Your chart and account will be reopened on a cash basis only and after paying total charges.

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our credit manager. This will avoid misunderstandings and enable you to keep your account in good standing.

Communicating with out patients is extremely important. Please let us know if you have any questions, comments, suggestions or concerns. We want you to feel very comfortable during your visits and look forward to a long-lasting relationship based on mutual respect and communication.

Thank you for choosing us. Welcome!

Sincerely,

Business Office

Agreed on this _____day of _______________ of 20____.

____

Signature of Patient or Legal Guardian

Jorge A. Saldivar M.D., P.A.

Account #:______________________

Patient's Name ______ Date of birth ______ Social Security Number ______

Spouse or Legal Guardian's Name ______ Relationship to patient ______ Marital Status: ______ (M) Married (S) Single

Address ______ Home telephone ______ Cellular telephone ______

City/ State/ Zip ______ Work telephone ______ Ext. ______ Best number to call: [ ] Hm [ ] Wk [ ] Cell

Employer's Name ______ Department ______ Occupation ______

Name of your Primary Care Physician (P.C.P.): ______ Patient e-mail address______

Referred by: [ ] Dr.______ (Name and phone number of Dr. that referred you to us) [ ] Other______ (How did you hear about us?)

Insurance Information

Please understand that all insurance requirements are the patient's/guarantor's responsibility, (including pre-certification). In most cases, we will file claims to insurance companies as a courtesy to our patients; however, the bill remains the patient's responsibility.

Primary Insurance Name ______ Secondary Insurance Name ______

Phone Number ______ Phone Number ______

Policy # ______ Group # ______ Policy # ______ Group # ______

Insured party's name ______ $______ Co-pay Insured Party's name ______ $______ Co-pay

Insured Information (if other than patient): ______ Name ______ DOB ______ SSN ______

Patient's relation: ______ (S) self, (W) wife, (C) child ______ Employer ______ Work Telephone Number ______ Ext.

We need two emergency contacts:

1) Name: ______ Phone: ______ Relationship: ______
2) Name: ______ Phone: ______ Relationship: ______

Certification, request and authorization

"By signing below, I certify that the information in this form is true and complete to the best of my knowledge. I understand this information will be used for regular medical office operations as stipulated in the notice of Privacy Practices for Jorge A. Saldivar, M.D. P.A.. A copy of this notice has been provided to me, I have read it, and understand my rights under this policy. I authorize this office to use this information as they deem necessary to contact me, to collect on charges, to submit claims to my insurance carrier(s), and to perform the regular business operations of this practice. I understand and authorize that my information might be transmitted electronically and via facsimile and I further authorize this office to release my information to physicians, medical facilities, and providers involved in my healthcare and understand that this authorization is valid for the next 24-month period.

I certify that to my knowledge, I only have the healthcare insurance coverage provided by the insurance carrier(s) named above and authorize these carriers to issue direct payment to Jorge A. Saldivar, M.D., P.A. on my behalf for services rendered. I understand that if there are any changes in my information, including insurance coverage, I must notify this office immediately."
I also certify that with my signature below that I give Jorge A. Saldivar, M.D., P.A. my informed consent to instruct, guide and treat my healthcare needs. I also authorize Dr. Saldivar to perform the clinical test(s) that, per his discretion, feels are necessary, in an attempt to ensure the best possible outcome.

Patient's/ Legal guardian's Signature: ______ Date: ______

(Please allow us to obtain a copy of your insurance card and picture ID). T h a n k Y o u !

PATIENT MEDICAL INFORMATION

Name: ____ DOB:__________ Age:_________

Reason for your visit: ____

Pregnancy History:

Number of times ever pregnant	Number of live births	Number of miscarriages	Number of abortions

Menstrual History:

Age when you got your first period? (Menarche): __________Date of the first day of your last period (L.M.P.): _________________
Number of days between periods: ______________ How many days do your periods last? ______________________
Flow is: [ ] Normal [ ] Heavy [ ] Light Number of pads in a 24 hour period of heaviest flow:____________
Pain with periods? __________ If yes, is your pain [ ] mild [ ] moderate [ ] severe. Any premenstrual symptom (bloating, mood swings, etc)? ______ If yes please describe: ____

Pap smear history:

Last Pap smear date: ________________ Place: ______________________________ Result: __________________
Have you ever had treatments for abnormal Pap smear? _________ If yes describe: ______________________________

Contraceptive history:

Have you ever used contraceptives? _________ If yes, name:____
What method(s) are you currently using? ______________________________ for how long? _________________
Are you attempting pregnancy at this time?______________________________ for how long?__________________
What contraceptive method do you want to use now, if any? ____

Social Habits:

Do you smoke tobacco? _______________ If yes, # of packs per day________ for how many years? __________
Do you drink alcohol? _________________ If yes, # drinks ____________ per week.
Do you use street drugs? _______________ If yes, what type(s) and amount______________________________
Did you ever use street drugs? ___________ If yes, what type(s) _____________________ when did you quit? __________________

Review of current systems. Do you currently have the following complaints? Please mark all that apply:

[ ] Burning, pain or frequent urination. How long?____
[ ] Vaginal discharge. If yes, describe____
[ ] Loss of urine with cough or sneeze. How long?____
[ ] Chest pain. Have you seen a cardiologist?____
[ ] Difficulty breathing____
[ ] Spotting/ bleeding after intercourse? ____
[ ] Recent significant weight change. Indicate if you lost or gain and # of pounds________________
[ ] Frequent headaches? How long?____
[ ] Dizzy spells? How long?____
[ ] Stomach or intestinal pains? How long?____
[ ] Fever now or recently?____
[ ] Hay fever allergies, respiratory problems?____
[ ] Work problems?____
[ ] Family problems?____
[ ] Depression?____
[ ] Suicidal thoughts?____

Current Medications and dosages ____

____

List all medications you have had allergic reactions to:________________________________

____

Explain what your reactions were:____

____

Name___________________________________ **DOB:** ________________

Past Hospitalizations and operations, state dates and reason for admission:

____

____

Medical History. **Please indicate type of problem and who suffers it.**

X	Disease	**SELF**	Father	Mother	Sibling	Other / Comments
	High Blood Pressure					
	Heart Disease					
	Asthma					
	Emphysema / lung disorder					
	Diabetes					
	Liver disease					
	Kidney problems					
	Stomach / intestinal problems					
	Rheumatic fever					
	Epilepsy					
	Bleeding disorders					
	Anemia					
	Depression					
	Emotional problems					
	Breast disease / lump					
	Bone / Joint disease					
	Cancer (state type of Cancer)					
	Stroke					
	Phlebitis / Varicose veins					
	Clots in veins or lungs					
	Migraine headaches					
	Malaria / Tropical disease					
	Hepatitis					
	Rubella					
	Varicella (chicken pox)					
	EBV (Epstein Bar virus)					
	CMV					
	Sexually transmitted disease					
	Infection of uterus/tubes/ovaries					
	Thyroid problems					
	Birth Defects					

The following questions are important to determine your risk for Cancer and other diseases. Like all information it is kept confidential.
Total # of sexual partners: 1-3[ ], 3-5 [ ], 5-10 [ ], 10+ [ ] Age at first intercourse _________Are you sexually active now? ________
Do you engage in sexual activity other than vaginal intercourse? _____________
[ ] Decreased sex drive [ ] Pain with intercourse [ ] Bleeding after/during intercourse [ ] History of sexual abuse

Pregnancy history. Please write the following information for each one of your pregnancies.

Month And Year	# of wks at deliv	Baby's Sex	Baby's Weight	Problems during pregnancy	Hrs in labor	Place of birth	Problems during delivery	Vaginal or C/Sec

Patient Name: ___________________________________ Account #:____________

Patient Preference Regarding Communication of Health Information

Who to Contact

I hereby give permission to **Jorge A. Saldivar, M.D., P.A.** to disclose and discuss any information related to my medical condition(s) with the following family member(s), other relative(s) and/ or close personal friend(s):

________________________________ ______________________________
Name Relationship

________________________________ ______________________________
Name Relationship

☐ I DO NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical condition(s).

How to Contact

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of communication, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

If method of communication is by phone, please check the appropriate box:

☐ OK to leave a message with detailed information.

☐ Leave a message with call back number only.

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other

Please print phone number clearly: ________________________________

In-Clinic Communication Only

☐ I request that communication regarding my medical condition(s) to occur ONLY when I am in the office. Please print and hand me information when I am in the clinic**.** **DO NOT** call, mail or otherwise communicate with me regarding my medical condition(s).

The duration of this authorization is indefinite unless, otherwise revoked in writing. I understand that request for medical information from person not listed above will require my specific authorization prior to the disclosure of any medical information.

______________________________________ __________________________
Signature of Patient or Legal Representative Date

___________________________________ ________________________
Name of Legal Representative Relationship to Patient

SELF-ASSESSMENT

Please complete and return this form to the front office.

NAME:____________________________________ DATE OF BIRTH:__________ DATE:__________

Other than the services we provide for you, what additional services would you like to learn about?

Select which areas of the face and/or body that concern you on the diagram below.
By sharing how you see yourself, we can best evaluate your aesthetic goals or health concerns and select the appropriate treatment for you.

- ☐ Pore Size
- ☐ Acne / Scarring
- ☐ Volume Loss
- ☐ Blood Vessels / Rosacea
- ☐ Dark Circles
- ☐ Crows Feet
- ☐ Eye Bags
- ☐ Fine Lines / Wrinkles
- ☐ Under Chin Fat
- ☐ Lip Volume or Fullness

<u>Frequent Sweating</u>

- ☐ Underarms
- ☐ Hands
- ☐ Feet

- ☐ Sun Spots

- ☐ Excess Weight
- ☐ Muscle Toning
- ☐ Loose Skin
- ☐ Stretchmarks
- ☐ Loose skin above the knee
- ☐ Cellulite
- ☐ Frequent Urination
- ☐ Dryness / Painful Intercourse
- ☐ Vaginal Laxity
- ☐ Hair Removal