SAN LUCAS SURGICAL ASSOCIATES

Rolando H. Saenz, M.D, F.A.C.S

New Patient Information: **Today's Date :** _____

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Date of Birth:_____**Sex:** M__ F__ **S.S #:**_____ **Marital Status:**_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Mobile Phone:**_____ **Work Phone:** _____

Email:_____**Preference:** (Home phone) (Mobile Phone) (Work Phone) (Email)

Authorization: I authorize you to leave reminder calls on my mobile device. **Yes**____ **No**____

Referring Provider:_____ **Preferred Language:** Spanish_____ English_____

***Primary care Physician & Phone Number*:**_____

Race / Ethnicity: (African American or Black) (Hispanic or Latino) (American Indian or Alaska Native) (White) (Native Hawaiian or Other Pacific Islander) (Asian) (South American) (Other)

***Emergency Contact Info*:**

Last Name:_____**First Name:**_____**Phone:**_____**Relation:**_____

***Insurance Info*:**

Ins. plan Name:_____**Policy Holder Name:**_____**Policy Holder DOB:**_____

***Employer Info*:**

Employer Name:_____ **Employer Phone:**_____ **Occupation:** _____

Protected Health Information Authorization: Please list below any family members or others who you would like to involve in your care. Please indicate below what type of information you authorize us to share for each listed person. (we will continue to rely on the info given here when communicating with family members or others involved in your care unless you request changes.)

			Type of Information :		
Name :	**Relation :**	**Phone #:**	***Scheduling***	***Medical***	***Billing***
			All Y/N	Y/N	Y/N
			All Y/N	Y/N	Y/N
			All Y/N	Y/N	Y/N

Today's Date:_____/_____/_____

Patient Name:_____ **Date of Birth:** _____/_____/_____

Pharmacy Name & Number:_____

Reason for being seen: _____

Allergies to Medication: Y/N Explain:_____

***Medications*:** Please list all medications you are currently taking including prescribed, OTC, and any vitamins or herbal supplements below.

MEDICATION	DOSAGE	HOW MANY TIMES PER DAY	REASON FOR MEDICATION

***Past Medical History*:** Please circle 'Y' for YES and 'N' for NO for medical problems listed below.

Y / N Anemia
Y / N Anxiety / Depression
Y / N Arthritis / Gout
Y / N Asthma
Y / N Autoimmune
Y / N Bleeding Disorder
Y / N C.A.D / A-Fib
Y / N Cancer if Yes, Type?_____
Y / N C.H.F
Y / N C.O.P.D
Y / N Covid-19
Y / N Covid-19 Vaccine
Y / N Diabetes
Y / N Diverticular Disease
Y / N Gastritis / Ulcers / G.I Bleed
Y / N HIV / Aids
Y / N Hepatitis
Y / N High/Low Blood Pressure
Y / N High Cholesterol
Y / N Kidney Disease / stones
Y / N Myocardial Infarction
Y / N Overweight / Obesity
Y / N Sexually transmitted Disease
Y / N Stroke
Y / N Thyroid disease
Y / N Tuberculosis (or positive TB test)
Y / N Headaches / Migraines
Y / N Rectal Bleeding
Y / N Fecal Incontinence
Y / N Seizures / Convulsions

Today's Date:_____/_____/_____

Patient Name:_____ **Date of Birth:** _____/_____/_____

***Surgical History*:** Please list any previous surgeries or procedures

Surgery / Procedure	Date	Surgeon	Hospital

Date of last Colonoscopy: _____/_____/_____

Date of last Endoscopy: _____/_____/_____

***Family History*:** (please put **N/A** below if this does not apply to you)

RELATION	PROBLEM	ONSET AGE	AGE OF DEATH	NOTES / COMMENTS

***Social History*:**

Alcohol Consumption: Y / N (Beer, Wine, Liquor, Cocktails)

If yes, how much do you consume? _____Drinks Daily _____Drinks Weekly _____Drinks Monthly

Smoking Status: Current everyday smoker; Current some day smoker; Former smoker; Never Smoker

If yes, how much do you smoke? _____PPD _____PPW _____Other **(include type if not listed below)**

Tobacco years of usage: _____ ***Type*:** Cigarettes; Chewing tobacco; Electronic cigarette

Illicit Drugs: Y / N If yes, Explain:_____

ADDITIONAL INFO: _____

_____

_____

New Patient Acknowledgements:

***MEDICATION REFILL REQUESTS*:** We ask that you first contact your pharmacy for refills. Refills should be requested at least 72 hours (3 business days) prior to the date you would like your medication filled. Any refill requests made over the weekend may not be reviewed as our office is closed. If you have not been seen by Dr.Saenz in the past year, you will need to be seen in office before your refill can be fulfilled.

***PAYMENTS*:** Full payment of all applicable fees, deductibles, coinsurance, co-pays or outstanding balances, is due prior to services provided. We accept cash, personal checks, Visa®, Master Card®, American Express®, and Discover®. There is a $25.00 charge for all returned checks.

TELEMEDICINE: In the event of a Tele-med visit (existing patients only), you may be charged a fee in accordance with your insurance's benefit plan (Deductible, Copayment, Co-Insurance or Out-of-Network), usual and customary charges. Please inquire with our staff at least 24 hours prior to your appointment date in the event you would like to change your visit to a Telemedicine, if you are unable to make an in-person visit.

***CHANGES OF INFORMATION*:** Please update us with any changes regarding your address, phone number, or insurance as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

***FMLA & OTHER FORMS*:** If you will be needing any FMLA or other applicable paperwork filled out by our office. Please be aware that there is a minimum fee of $40.00, this can be paid either when you drop off or pick up your paperwork. Please allow us up to 7 business days to complete your forms.

APPOINTMENTS/'NO SHOWS'*:** We ask that you arrive on time to your appointments. There is a grace period of 15 minutes, after this you will be considered a ***'no show'. If there is an instance of traffic or like there of, please call our office and let us know as we will be more than happy to work with you. Patients who miss a minimum of 3 appointments over a 12 month period will be considered a ***'chronic no show'*** and may be discharged as a patient from the practice.

***CANCELLATIONS*:** Please acknowledge and understand that missed appointments without 24-hours advance notice will be subject to a $40.00 '*no show*' fee which must be paid in full before future appointments will be scheduled.

***OFFICE VISITS*:** In respect to all of our patient's time and also to maintain efficiency of our office, only complaints / concerns for which the visit was scheduled should be addressed. We will do our absolute best to address all of your healthcare needs, but this may require multiple visits.

By my signature below, I acknowledge having read, understand, and am in agreement with the information listed above, and will act within these expectations.

Patient Signature	**Printed Name**	**Date**

Policy Acknowledgements & Releases:

Please read each of the following statements carefully, and sign the bottom of the page as your authorization that you understand and agree with each statement.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I understand that I am financially responsible for the balance in full.

I understand that it is my responsibility and obligation to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and agree to make payment in full.

I understand that it is my responsibility to know if my insurance requires a referral from my primary care physician, and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

Financial Obligation: I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

Surgical/Procedure Estimated Fees: Estimated fees will be collected at your appointment following your surgery/procedure. Should you need payment assistance or to set up a payment plan, please notify our office. After three unsuccessful attempts to collect payment, the bill will be turned over to our outside Collection agency and you will be discharged as a patient from the practice.

Medicare Beneficiary and Release: I understand that I need to provide the office with both my Medicare ID card and my secondary ID card (if applicable). If the office does not have the proper information for your secondary insurance, it will not be billed. I acknowledge that it will be my responsibility to pay the full balance and to file a claim with my secondary insurance for reimbursement.**(only sign if you are a patient with Medicare)** ***Patient Signature***:_____

Consent For Treatment: I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. San Lucas Surgical Associates provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Advanced Directive: Do you have an advanced directive? **(living will/power of attorney?)** **Yes / No**

If Yes, please provide our office a copy for our records.

TX Prescription Monitoring: I authorize San Lucas Surgical Associates to use the Texas Prescription Monitoring program prior to any dispensing of controlled substances.

By my signature below, I acknowledge having read, understand, and am in agreement with the information listed above.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**

SAN LUCAS SURGICAL ASSOCIATES

Medical Records Release Form

Patient's Name: _____ DOB: ____/____/_____

Social Security Number: ____/____/_____

Please release my records to:

Rolando H. Saenz, MD., F.A.C.S.

1303 McCullough Ave., Ste. 362

San Antonio, Tx, 78212

P: 210.941.1000

F: 210.222.8200

Information Requesting: (LEAVE BLANK)

__ Complete Medical Records

__ Labs/ Radiology Reports

__ Procedure/ Pathology Report

__ Office progress notes

If other, please specify: _____

I hereby authorize you to release my confidential health information by releasing a copy of my medical records to the person or entity listed above. This authorization is valid for one year from the date of my signature, I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulation. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing.

_____ ____/____/_____

Patient Signature Date