Maria Pilar Faylona M.D.

Board Certified * Family Practice Diplomate American Board of Family Practice 4212 W.Charleston Blvd., Las Vegas. Nevada 89102
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Medical Record Form

NAME:_____ **BIRTHDATE:**___/___/__ **AGE:**_____
mo / day / year

MARITAL STATUS:_____ **OCCUPATION:**_____ **RACE:**_____

ALLERGIES

CURRENT MEDICATIONS

HOSPITALIZATIONS OR SURGERIES

PLS. CIRCLE IF YOU HAVE ANY OF THE FF:

CENTRAL NERVOUS SYSTEM

Migraine or Headaches
Stroke / CVA / Transient Ischemic attacks
Convulsion or Epilepsy

EENT

Cataracts / Glaucoma / Visual defects
Sinusitis, Tonsillitis, Allergies, Ear infection

CARDIOVASCULAR SYSTEM

High Blood Pressure
Heart Disease
Pacemaker, Valvular defects
Blood Clots

RESPIRATORY SYSTEM

COPD / Bronchitis / Asthma
Pneumonia
Respiratory Failure

GASTROINTESTINAL SYSTEM

Heartburn, Gastritis, Ulcers
Colon Polyps, Diverticulitis, Hemorrhoids
Hernia, Hepatitis, Gallstones
Changes in Bowel habits or blood in stool

GENITOURINARY

Prostate enlargement / Frequent urination_____
Kidney disease / stones / infection_____

FAMILY HISTORY

	Father	Mother	Siblings
Psychiatric illness			
Heart Disease			
Hypertension			
High cholesterol			
Diabetes			
Cancer			

SOCIAL HISTORY

Cigarettes? Y : N ; amount:___How long?__Quit?___
Chew, Pipe? Y : N
Alcohol? Y : N ; / amount:__How long?__Quit?__
Street Drugs? Y : N; / Kind:___How long?__Quit?__

GYNECOLOGIC SYSTEM

Age of first menstruation_____
Date of last menses_____
Are you Pregnant? Y : N
Vaginal Infections? Y : N
Sexually Transmitted Disease? Y : N
Form of Contraception_____

ENDOCRINE SYSTEM

Diabetes_____
Hypothyroid/Hyperthyroid_____

MUSCULOSKELETAL

Osteoporosis_____
Arthritis/ Bursitis/Tendonitis_____
Fractures_____
Back Problem/Accidents_____
Carpal Tunnel syndrome_____

BLOOD/ LYMPHATICS/ NEOPLASM

Cancer_____
Abnormal Lymph Nodes/Mass/Lumps_____
Anemia and blood diseases_____

PATIENT AND INSURANCE INFORMATION

PATIENT INFORMATION

First Name:_____ Date of Birth:_____/_____/_____
month / day / year

Middle:_____ Sex: Male / Female

Last:_____ Social Security #:_____

Address:_____ Marital Status: Single / Married

_____ Divorced / Widowed

City:_____ Tel. (Home): (____)_____

State:_____ Tel. (Work): (____)_____

Zip Code:_____ Cell phone: (____)_____

Occupation:_____ Email:_____

Employment Status: Employed / Part Time Student / Full Time Student / Retired / Other

Employer's Name:_____

Employer's Address:_____

SPOUSE INFORMATION (if applicable)

First Name:_____ Date of Birth:_____/_____/_____
month / day / year

Middle:_____

Last:_____ Social Security #:_____

Employer's Name:_____

Employer's Address:_____

RESPONSIBLE PERSON (if applicable)

Name:_____ Relationship to Patient:_____

Address:_____ Date of Birth:_____/_____/_____
month / day / year

Tel. (Home): (____)_____ Social Security #:_____

Tel. (Work): (____)_____

Financial responsibility Statement

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Relationship to Insured: _____

Date of Birth: _____/_____/_____
month / day / year

Social Security #: _____

Secondary Insurance: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Name of Insured: _____ Relationship to Insured: _____

Date of Birth: _____/_____/_____
month / day / year

Social Security #: _____

Medicare Patients

I request that payment of authorized Medicare benefits be made to me on my behalf to Maria Pilar Faylona MD PC for any service furnished me by Dr. Maria Pilar Faylona. I authorize that any holder of medical records about me to release to the Health Care financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as the original.

Non-Medicare Patients

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and or surgical benefits, including major medical benefits to which I am entitled, to Maria Pilar Faylona M.D.. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

I assume financial responsibility for all charges.
I have read the above information and understand it.

Patient: _____ Date: _____
(if patient is a minor, a parent's signature is required)

Financial Summary

PLEASE INITIAL ALL

_____ I hereby authorize the payment of medical benefits directly to Maria Pilar Faylona M.D. for any and all services rendered.

_____ I understand that while Maria Pilar Faylona M.D. will complete the insurance forms needed to file a claim for benefits from my insurance carrier, it remains my personal responsibility to pay for services rendered.

_____ I understand that I am responsible for payment of services applied to co-insurance, deductible, and non-covered services. This is determined by the insurance carrier, i.e. Medicare, Champus, preferred provider plans (PPO), health insurance organization (HMO) etc.

_____ I am aware that I will be charged a $50.00 fee for an Attending Physician Statement.

_____ I understand there will be a photocopying fee of $.60 per page for medical records furnished. (NRS 629.061)

_____ I understand that I must provide Maria Pilar Faylona M.D. with a copy of a valid current I.D. If I fail to do so, I understand that I must make a prepayment of $100.00 prior to seeing the physician. This will be applied to the total charges of services rendered, if I do not have current health insurance. (NRS.431,2)

_____ I authorize Maria Pilar Faylona M.D. To release any information necessary to a requesting physician, hospital, or any medical facility.

_____ I authorize Maria Pilar Faylona M.D. to release any information that is requested by my insurance carrier for the processing of my medical claim.

_____ If for any reason, I give fraudulent insurance or personal information to Dr.Maria Pilar Faylona or his staff that prevents a claim from being paid, I will be assessed a $100.00 fee and billed directly for any / all services provided.

_____ I understand should my account become 90 days deliquent from the first statement that was mailed, a 5% finance charge will be added to my unpaid balance. I also understand a deliquent account may be assigned to a third party collection agency and/or subject to the legal process. Unpon assignment, additional fees incurred (up to 50%) for such services as noted above, including finance charges, will become my full responsibility.

➡ _____ _____

Signature (If minor, parent signature required) Date

There is a finance charge applied to any account balance that is over 30 days past due. The rate of 1.5% monthly, 18% annual rate applies.

All patient information forms must be updated yearly.
We have the right to refuse service to any one.

CONSENT TO TREATMENT

I voluntary consent to receive medical and health care services that may include diagnostics procedures, examinations, and treatment.

Financial responsibility and Assignment of Benefits.

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

➡ _____ _____

Patient or other Legally Authorized Person Date

Maria Pilar Faylona M.D. 4212 W. Charleston Blvd., Las Vegas, Nevada 89102

Consent For Use and Disclosure of Health Information

This notice describes how medical information about you may be used and disclosed, your rights as a patient, and always for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:
-For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
-For billing and collection purposes, we may release records of your health care information that you have provided to your insurance carrier or other financially responsible parties.
-For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Doctor.

If you would like further information about our privacy policies and practices please see the "NOTICE OF PRIVACY PRACTICES" binder in reception or ask for a copy at the Front desk.

Name (Printed please)	Signature	Date

If you are a minor, or if you are being represented by another party:

Personal Representative (Printed)	Personal Representative's Signature	Date

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Cancellation and No-Show Policy

We ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep your appointment. We would like to have the option to offer that appointment to another patient who needs medical attention.

This letter serves as notice that if you fail to give us a 24- hour notice of cancellation, there will be a $25.00 Cancellation/No-Show fee billed to your account that is non-covered by your insurance. You will bear complete financial responsibility for this fee. Cancellation Fee/No-Show fee due prior to next visit.

_____ _____

Patient Signature Date