UNIVERSITY MEDICAL CARE, PA

PATIENT INFORMATION - INFORMACIÓN DEL PACIENTE

PATIENT NAME NOMBRE DEL PACIENTE				BIRTHDATE FECHA DE NACIMIENTO	SEX SEXO
ADDRESS DIRECCIÓN	CITY CIUDAD	STATE ESTADO	ZIP CODE ZIP CODE	SOCIAL SECURITY NUMBER NUMERO DE SEGURO SOCIAL	MARITAL STATUS ESTADO CIVIL ☐ SINGLE ☐ SOLTERO(A) ☐ MARRIED ☐ CASADO(A) ☐ DIVORCED ☐ DIVORCIADO(A) ☐ WIDOWED ☐ VIUDO(A)
HOME PHONE TELEFONO DE CASA	CELL PHONE TELEFONE DE CELLULAR	EMPLOYER PATRÓN	ADDRESS DIRECCIÓN		EMPLOYER PHONE # TELEFONO DEL PATRÓN
ARE YOU RETIRED ESTÁ USTED RETIRADO ☐ YES ☐ NO	DATE OF RETIREMENT FECHA DE RETIRO	ARE YOU DISABLED ESTÁ USTED INCAPACITADO ☐ YES ☐ NO	DATE OF DISABILITY FECHA DE INCAPACIDAD		DO YOU HAVE INSURANCE TIENE USTED SEGURO ☐ YES ☐ NO
SPOUSE/GUARDIAN NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO		EMPLOYER PATRÓN			EMPLOYER PHONE # TELEFONO DEL PATRÓN
NEAREST RELATIVE NOT LIVING WITH YOU NOMBRE DE OTRO FAMILIAR QUE NO VIVA CON USTED	RELATIONSHIP RELACIÓN	ADDRESS DIRECCIÓN			PHONE TELEFONO
EMERGENCY CONTACT CONTACTO DE EMERGENCIA		ADDRESS DIRECCIÓN			PHONE TELEFONO

PRIMARY INSURANCE INFORMATION - INFORMACIÓN PRIMARIA DEL SEGURO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCIÓN		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NÚMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

SECONDARY INSURANCE INFORMATION - INFORMACIÓN DE SEGURO SECUNDARIO

NAME OF INSURANCE COMPANY NOMBRE DE COMPAÑIA DE SEGURO		ADDRESS DIRECCIÓN		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NÚMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NÚMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

LIFETIME AUTHORIZATIONF FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE - AUTORIZACION POR VIDA PARA ASIGNACION DE BENEFICIOS Y LIBERACION DE INFORMACION:

I hereby give consent to **University Medical Care, PA** to provide whatever treatment they deem necessary to the patient named above. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims.

I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

I assign payment directly to the physicians at **University Medical Care, PA** which may be due to me from the Medicare program or other health insurance company. I understand I am financially responsible to **University Medical Care, PA** for any non-covered insurance services.

Por este medico doy mi concentimiento a **University Medical Care, PA** para proveer cualquier tratamiento que ellos estimen necesario al paciente en referencia. Autorizo cualquier compania de seguro, organizacion, patrono, hospital, medico, dentista o farmaceutico a liberar cualquier informacion requerida para obtener autorizacion para futuro tratamiento y processamiento de reclamos.

Yo certifico que la informacion que estoy dando es cierta y correcta y que estoy conceinte que es una violacion de ley proveer informacion falsa y/o de informar informacion intencionalmente sabiendo que es importante.

Yo assigno pago directo a los medicos, en **University Medical Care, PA** que puedan estar debiendome del programa de medicare o cualiquier otra compania de serguro. Yo entiendo que soy responsible por cualquier deuda financiera a **University Medical Care, PA**

Patient or Responsible Party:_____ Date:_____

All necessary lab work will be billed separately by an independent laboratory. Please notify nurse of special laboratory requirements.

Paciente o persona responsible_____ Fecha _____

Todo trabajo de laboratorio sera facturado por separado por el laboratorio independiente. Favor de notificarle a la enfermera se cualquier requerimiento especial de laboratorio.

COMMERCIAL INSURANCE - SEGURO COMERCIAL

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Payment is requested at time of service for self pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Yo autorizo que se ofresca la información necesaria para asi someter un reclamo con mi compañia de seguro y qué los beneficios sean asignados a mi o de otro modo a mi doctor o el grupo indicado en la forma del seguro. Yo tengo entendido que yo soy responsable por cualquier balance que mi seguro no cubra. Una copia de esta firma es valida como la original.

El pago es requerido al tiempo que se rinden los servicios a todo paciente no asegurado. Alguien de nuestro departamento de seguro puede asistirle si necesita un arreglo de pagos mensuales. Nosotros podemos asistirle en llenar las formas para su seguro. Su poliza de seguro es un contrato entre usted y la compañia de seguro. Usted es responsable de los pagos.

Signature / Firma _____ Date / Fecha _____

Witness / Testigo _____ Date / Fecha _____

FOR OFFICE USE ONLY	ACCT. #	CO PAY $	DEDUCTIBLE	☐ DR. KAPOOR	☐ DR. PURI

471 N SEMORAN BLVD, SUITE A WINTER PARK FL 32792

New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

Patient's Name: _____ Date: _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing quality care and Service to all of our patients. The following is a statement of our financial policy, which we require that You read and agree to prior to any treatment.

It is your responsibility to know your own insurance benefits, including whether we are a Contracted provider with your insurance company, your covered benefits and any exclusions in Your insurance policy, and any pre-authorization requirements of your insurance company

As a patient of University Medical Care, PA I have been informed of the following:

- It is my responsibility to know if there are any deductibles, copays, clauses and/or exclusions in my insurance policy that would prevent the insurance company from paying any of my claims.

- It is my responsibility to provide University Medical Care, PA with accurate insurance information to submit claims on my behalf. Should you failed to provide this information you will be financially responsible. We will need a copy of your insurance card and photo ID.

- My insurance company may not cover ALL physician fees, and I will be responsible for payment if my insurance company denies payment

- It is my responsibility to obtain physician referrals if needed. If a referral is not obtained, but treatment is provided as an emergency you are still responsible.

- The insurance company denies payment; it is my responsibility to make payment for any outstanding charges.

- The office bills my insurance company for all visits, office procedures and laboratory fees performed IN office. Any questions related to outside bills should be directed to whoever provided the services.

- I understand that some insurance companies have timely filing limit reference to submission of medical claims. I understand that information in regards to correct insurance policies must be given to the office within that time frame or I, as the patient, am solely responsible.

My signature below indicates that I understand the information explained above. I acknowledge my financial responsibility for all charges including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges.

_____ _____

Signature of patient or legal guardian **Date**

OFFICE POLICIES

8 policy rules that keep our office running smoothly

Welcome to University Medical Care, PA. We recognize that you have a choice when it comes to your healthcare and we are honored that you chose us. We want each patient to have an ideal experience with our practice. In an effort to keep this process as smooth and problem free as possible, we must ask that the following policies be adhered to.

1- **All clinically related phone calls go through our Nurse Triage lines. You will be asked to leave your full name, birth date and phone number along with your immediate problem on our Triage Nurse Voicemail. The appropriate nurse will return your call. This will allow her the opportunity to have your medical record available to best equip her to manage your situation. Please be sure to leave a number where you can be reached during daytime hours. Calls are returned in order of urgency, not necessarily in the order that they are received. Multiple messages will delay your returned phone call. Please be assured that every effort will be made to return your call the same day. Messages left after 4:00pm may not be returned until the next business day.**

2- **Please allow 48-72 hours for prescription refills. Prescriptions will only be filled Monday-Thursday between 8:30am and 4:00pm and on Friday's between 8:30am and 11:30am. Please have your pharmacy contact our office for refills. In order for prescription refills to be approved by your doctor, you must have been seen within the past 3 months.**

3- **The refill of pain medications or sleep medications is not considered an emergency and will not be addressed on a weekend or holiday. If it looks like you might run out over a weekend, please plan accordingly and call our office before the weekend during the times noted above to allow us the time to accommodate your request.**

4- **Please allow 10-14 days for after lab tests and/or diagnostic testing results.**

5- **The completion of disability forms and/or special request letters is time consuming and will take 7-10 days. There is a $25.00 charge for the completion of these forms.**

6- **If we referred you to another physician for consultation we will forward your records to that physician to insure your continuation of care. If, however you want copies of your records for any other reason there is a nominal charge for these copies. The charge is $1.00 per page for the first 25 and $0.25 per page for each subsequent page. Please allow 7-14 business days for this request to be completed.**

7- **We highly recommend that you keep all your schedule appointments. If you need to cancel or reschedule and appointment please allow us the courtesy of a 24 hours' notice. If you fail to give us 24 hours' notice or if you do not show up for your appointment you will be charged a fee of $50.00.**

8- **If you are over 15 minutes, it is at the physician discretion if you will be accommodated for your appointment.**

_____ _____

Patient's Signature Date

_____

Printed Name

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

University Medical Care, PA

Rajan Kapoor, MD Rajnish Puri, DO

Understanding your health insurance policy and payment practices

As a patient, you should be involved in your medical treatment and in paying for your health care. The following information will help you understand your health insurance policy and the health care payment process.

UMC office staff follows the rules of your health insurance policy. We work hard to send bills on time to your insurance company for payment so you will not have to pay for medical care covered by your health insurance. In some cases, we may need your help when bills are sent to your health insurance company to make sure your bills are paid on time.

Frequently asked questions about paying medical bills

1. What is a health insurance policy?

Your health insurance policy is a contract between you and your health insurance company. It is an agreement that your health insurance company will pay for covered medical care as long as your premium is paid. The health insurance company may not pay for every bill. This is why it is important for you to know which medical treatments the insurance company will pay for and which expenses it will not cover. You are responsible for paying some medical costs that the insurance company does not pay.

2. What are some common insurance terms I should know?

Be sure to check with your health insurance company to see how these terms apply to your health insurance coverage.

- **Co–payment or "co–pay" The** part of your medical bill you must pay each time you visit the doctor. This is a pre–set fee determined by your insurance policy.
- **Co–insurance** The part of your bill, sometimes in addition to a co–pay that you must pay. Co–insurance is usually a percentage of the total bill – for example 20%.
- **Deductible** The cost you must pay for medical treatment before your health insurance company starts to pay – for example $500 per individual or $1500 per family. It most cases, a new deductible must be met each year.
- **Non–covered charges** Costs for medical treatment that your health insurance company does not pay. You may wish to determine if your treatment is covered by your health insurance policy before you are billed for these charges by the doctor's office.

- **Approval Number** A number authorizing the health insurance company to pay benefits for your care. You may need to obtain an approval number from your health insurance representative before you see the doctor in order for the insurance company to pay for your medical treatment. Our office staff might be able to help you obtain approval from the health insurance company.

3. How is my doctor's office paid?

You should pay your co–payment and deductible, if required, during your visit to the doctor. While you are responsible for your medical treatment, this office will make every effort to seek payment from your health insurance company for the amount owed under your policy. The process by which the office seeks payment is complicated, which is why the office needs correct information from you.

4. What information should I bring to the doctor's office?

- Photo identification, such as a driver's license or passport.
- Current health insurance card; and
- Any changes in personal information such as your name, address, employer, or phone number.

5. If the doctor is seeing my child, (18 or older) what information should I bring to the office?

- Your health insurance card or the card of the person who covers the child's medical care; and
- The name of the person responsible for the child's medical care decisions and payment.

The doctor's office will also need to know your relationship to the child.

6. Why does the doctor's office need my personal and health insurance information to get paid?

Our staff uses this information to confirm your health insurance coverage and to send your insurance company a request for payment of your bill. The insurance company requires your personal and health insurance policy information before it will pay your bill. Be sure we have your current health insurance policy information, including the health insurance company name and address, policy number, group number, etc., so the health insurance company can pay your medical bill on time. Much of this information may have changed since your last visit to the doctor. The services covered by your health insurance may also have changed. That is why many doctor's offices require you to provide this information at each visit.

7. What is a coordination of benefits form?

Many health insurance companies require you to fill out a form that tells the company whether you or another family member has other health insurance. Your insurance company needs this information to work with other insurers to determine which company pays for what service. It is important that you fill out this form and return it to the insurance company. Otherwise, your medical bill may not get paid or payment may be delayed.

8. What if the health insurance company does not pay or pays only a portion of my medical bill?

As a courtesy to you, our staff will contact the insurance company to ask why the bill was not paid. The health insurance company may ask the office to appeal or to re–send the medical bill with more information.

We will make every effort to get the bill paid. However, sometimes we may need your help. You may be asked to call your insurance company or your employer to ask why the bill has not been paid.

9. What are some common reasons a health insurance company may not pay for medical treatment?

- Services were provided for a pre–existing condition. Most health insurance companies will not cover treatment for medical conditions you have prior to obtaining coverage.
- The coordination of benefits form or other required forms were not completed by you.
- Treatment is not covered by your health insurance policy.
- The health insurance premium has not been paid, either by you or by your employer.
- The doctor is "out–of–network" which means your doctor does not have a contract or agreement with your health insurance company. If your doctor refers you to another doctor, be aware that if the referred doctor is out–of–network you may be responsible for a portion of the payment.
- Another health insurance policy requirement, such as obtaining prior approval for your medical treatment, was not followed.