**GREGORIO S. SANTOS, M.D.**

*WELCOME TO OUR PRACTICE*

**New Patient Form**:

Today's date: _____

First Name:_____Last Name:_____MI____

Date of Birth _____Gender M F T Marital Status :S M D W SS #_____- _____- _____

Language Preference_____Race:_____Ethnicity:_____

Address_____

City_____State_____Zip_____

Telephone Number Home _____ Work_____Cell: _____

Occupation_____

**INSURANCE INFORMATION**

**Primary Insurance Name_____**Policy # _____

Group #_____Policy holder's Name _____

**Secondary Insurance Name_____**Policy # _____

Group #_____Policy holder's Name _____

Name of a relative Not living with you_____Phone # _____

In case of Emergency who may we contact? _____

Phone #_____Relationship _____

Referred by _____

Email Address:_____@_____

Would you like to Participate in the Patient Portal? Yes No

Pharmacy Information

Local Pharmacy _____ Address _____

Mail Order Pharmacy _____ Phone # _____

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**Payment Policy:** Payment is due at time of service unless other arrangements have been made with office.

**I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS ON ASSIGNED CLAIMS TO GREGORIO S. SANTOS, M.D., P.A. I UNDERSTAND THAT GREGORIO S. SANTOS, M.D., P.A. WILL FILE CLAIMS FOR INSURANCE COMPANIES WITH WHICH THEY ARE CONTRACTED. THE FINANCIAL OBLIGATION FOR ALL DEDUCTIBLES, CO-PAYMENTS AND NON-COVERED SERVICES ARE MY OBLIGATION.**

**I authorize Gregorio Santos MD PA, their staff, and my pharmacy to release my information for electronic prescription services and external prescription history.**

Patient Signature_____Date _____

# MEDICAL INFORMATION AND HISTORY

NAME: _____ Date Of Birth: _____

Please complete the following information relating to your medical health.
This information will be part of your medical record

**Personal History**

| | Yes | No |
|---|---|---|
| Amputation | | |
| Anemia | | |
| Alcohol Overuse | | |
| Allergies | | |
| Arthitis | | |
| Asthma | | |
| Bleeding Disorder | | |
| Cancer | | |
| Cardiac Arrhythmias | | |
| Colitis | | |
| Depression | | |
| CVA/TIA | | |
| Diabetes | | |
| Emphysema / COPD | | |
| Falls | | |
| Gallbadder Disease | | |
| Gout | | |
| HIV / AIDS | | |
| Heart Attack / MI | | |
| Other Heart Conditions | | |
| Hepatitis | | |
| High Blood pressure | | |
| Jaundice | | |
| Kidney Disease | | |
| Migraine Headache | | |
| Nervous Breakdown | | |
| Ostomies | | |
| Paralysis | | |
| Rheumatic Fever | | |
| Seizures | | |
| S.T.D. | | |
| Sickle Cell Anemia | | |
| Sleep Disorder | | |
| Stomach Ulcers | | |
| Thyroid Disease | | |
| Cascular Disease | | |

**Personal Habits**

| | Yes | No | |
|---|---|---|---|
| Have you ever Smoked | | | |
| Current Smoker | | | |
| Packs per day | | years | |
| Other forms of Tobacco | | | |
| Do you consume alcohol | | | |
| how often | | | |

**Immunization History**

| | Yes | No |
|---|---|---|
| Flu shot | | |
| Pheumonia | | |
| Type | | |
| DPT | | |
| Hepatitis B | | |
| Shingles | | |

**Family History**

| | Healthy | | Explain |
|---|---|---|---|
| | Yes | No | |
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| Other | | | |

**Operations**

| Surgery Type | Date Month / Year |
|---|---|
| | |
| | |
| | |
| | |

**Hospitalizations**

| Reason | Hospital | Date |
|---|---|---|
| | | |
| | | |
| | | |

Name: _____ Date Of Birth: _____

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

| Medication | Dosage | How Often | When Started |
|---|---|---|---|
| | | | |
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Are you allergic to any medications (circle one): yes no If yes please list the reactions.

| Medication | Reaction |
|---|---|
| | |
| | |
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| | |

# Patient Self Determination Act

**In order to comply with the Omnibus Budget Reconciliation Act of 1990 and chapter 745, Florida statutes, please answer the following questions:**

***Declaration to Decline Life-Prolonging Procedure (Living Will)***

☐ I have made such a declaration

☐ I have ***NOT*** made such a declaration

***Health Care Surrogate***

☐ I have designated a Health Care Surrogate

☐ I have ***NOT*** designated a Health Care Surrogate

***Durable Power of Attorney***

☐ I have appointed a Durable Power of Attorney

☐ I have ***NOT*** Appointed a Durable Power of Attorney

**I have been provided information regarding the PATIENT SELF DETERMINATION ACT:**

_____

Please Print Full Name

_____

Social Security Number

_____

Signature Date

Revised 01/2006

Gregorio S Santos, M.D., P.A.
6125 54th Ave N, Suite B
Kenneth City, FL 33709
(727)521-9467 Fax: (727)521-0416

# Financial Policy

**1. PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit.

**2. INSURANCE** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service.

**Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage.** Not all insurance plans cover all services. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

**Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.**

**3. RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Pinellas County.

**5. ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

**6. FORMS FEES:** completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $25 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. Gregorio S Santos, M.D., P.A. will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

**7. BILLING OFFICE:** If you have questions in regard to any of your billing statements, our accounts receivable staff is available to assist you. CALL 727-521-9467.

Gregorio S Santos, M.D., P.A.
6125 54th Ave N, Suite B
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# Financial Policy

**8. CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $35 missed appointment fee.

**9. RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to Gregorio S Santos, M.D., P.A. for charges not covered by the assignment of insurance benefits.

**10. ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign, transfer, and set over directly to Gregorio S Santos, M.D., P.A. sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Gregorio S Santos, M.D., P.A. to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Gregorio S Santos, M.D., P.A. I authorize Gregorio S Santos, M.D., P.A. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

**12. SELF PAY PATIENTS:** Evaluation and management charges will be discounted for prompt payment. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. Gregorio S Santos, M.D., P.A. does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

**13. RELEASE OF INFORMATION:** I hereby authorize the and direct Gregorio S Santos, M.D., P.A. to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

**14. COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

**I certify that I have read these Financial Policies and Consent Procedures and understand and agree to be personally and fully responsible for payment.**

_____

Signature of Patient Date
(or Guarantor, if applicable)

_____

Please Print the Name of the Patient

Gregorio S Santos M.D., P.A.
6125 54th Ave N Suite B
St. Petersburg, FL 33709
Phone: 727-521-9467
Fax: 727-521-0416

# Patient Notice Of Privacy Practices

This notice describes how medical information about you may be disclosed. Please review it carefully.

Gregorio Santos M.D., P.A. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of the medical records to pay the claim.
3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVACY POLICY NOTICE of Gregorio Santos M.D., P.A. is posted in the waiting room for your perusal.

**QUESTIONS # 1, 2, & 3 MUST COMPLETED**

In conjunction with these practices you will need to provide us with the following information:

1. Name of Person(s) we may speak with regarding your health (i.e. spouse, child etc.) Please include Phone number.
   _____
   _____
   _____
2. Emergency contact: (Relative or person not living with you)
   Name: _____
   Address: _____
   Phone Number: _____
3. May we leave a message regarding your health or upcoming appointments on your answering machine?
   HOME YES_____ NO_____
   WORK YES_____ NO_____

_____ _____
Signature of Patient or Legal Guardian Relationship to patient

_____ _____
Print Patient's name or Legal Guardian Date