PIONEER MEDICAL ASSOCIATES

Dr. Lata Pablani, MD, Dr. Sainath Gaddam, MD, FACC, Dr. Mounica Gooty, MD
Lissy Joseph, APRN, FNP, Ana Lugo, APRN, FNP-BC , Swapna Joseph, FNP, Aparna Marwaha, AG- ACNP, Jerria Bernestine, FNP

Phone: 469-888-4890 Fax: 866-292-0929

NEW PATIENT REGISTRATION

Name (First, Middle, Last): _____

Date of Birth MM/DD/YYYY: _____ **Age:** _____ **Social Security Number:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip**: _____

Gender Identity: □Male □Female □Transgender (FTM) □Transgender (MTF) □Decline to answer □Other _____

Sexual Orientation: □Lesbian/Gay/Homosexual □Straight/Heterosexual □Bisexual □Decline to answer □Other _____

Main Phone: _____ **Alternative Phone**: _____

Email: _____

Reason for Visit: _____

Primary Care Physician's Name: _____ **Primary Care Physician's Phone:** _____

How did you hear about us? □ Internet ☐ Family/Friend ☐Social media ☐Hospital ☐ Other

_____ ***Emergency Contact*** **Full Name:**
Relationship:
_____ **Phone Number:** _____

Marital Status □Married □Single □Divorced □Separated □Widowed □Decline to answer.

Ethnicity □American Indian or Alaskan Native □Asian □Black or African American □White □Hispanic or Latino □Native Hawaiian or Other Pacific Islander □Decline to answer.

PHARMACY INFORMATION

Pharmacy Name: _____ **Pharmacy Phone Number:** _____

Pharmacy Address/Location: _____

INSURANCE INFORMATION

Company Name: _____ **Member ID:** _____ **Group No:** _____

RELEASE OF INFORMATION

Please list the individuals with whom we may discuss your medical information with OR check the box below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

CHECK HERE ONLY IF: □ I do **NOT** authorize discussion of medical information to any individual other than medical professionals involved in my care. This includes lab results, radiology reports, physician notes, prescription information, etc.

I certify that by my signature below, I give Pioneer Medical Associates permission to discuss my medical information with the individuals listed above. If you checked the box above, please also sign below.

_____ _____ _____

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

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LEGAL INFORMATION AND POLICIES

As a patient of Pioneer Medical Associates, I understand that the following policies are currently in effect:

Consent for Treatment: I authorize hereby and voluntarily consent to authorize Pioneer Medical Associates healthcare providers to provide healthcare services to me. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers.

Assignment of Benefits: I authorize my insurance benefits to be paid directly to Pioneer Medical Associates and its related companies. I understand that I am financially responsible for any balance my insurance fails to cover. I also authorize Pioneer Medical Associates, its related companies, or insurance company to release medical information required for claims. I understand I am responsible for knowing what my insurance plan does and does not cover.

Consent for Communication: I understand Pioneer Medical Associates will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders. Prolonged Care: In accordance with AMA CPT guidelines, we reserve the right to bill for telephone calls with our medical professionals that include evaluation and management of your medical condition, as well as time spent for extensive medical review or coordination of care. Payments: Payment is due at time of service, including copays, deductibles, co-insurance, and prior balance due. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments, deductibles, co-insurance, and prior balance from patients can be considered fraudulent. Please help us in upholding the law by paying your patient responsibility at each visit. To make payments convenient we require a card on file. We also accept visa, master card, American Express, cash and checks. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents. If you have any questions regarding this, please call your insurance company. If you are unable to pay for your visit, you will need to reschedule until you are able to cover the visit cost.

Deductible Based Plans: A deductible is the amount of money you must pay out-of-pocket before your insurance pays. Pioneer Medical Associates is responsible for collecting an estimated cost for all services rendered in office. The remainder balance due will be reflected upon claim submission and will be billed to you. In the event of an overpayment, we will refund you upon receipt of payment from your insurance.
Card on File: Card on File is REQUIRED for all patients to ensure an efficient and smooth check in process, along with reducing collection efforts. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care.
Non-payment: It is our office policy that all past due accounts be sent statements regularly. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to our collection agency and may result in discharge from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
Termination: Patients who are non-adherent to treatment plans, follow-ups, office policies or are violent/verbally abusive to providers and/or staff may result in discharge from the practice.

Annual/Physical Exams: This type of visit is PREVENTATIVE ONLY. If you are here for an Annual/Physical exam and want to be seen for other health issues in addition to this visit, then we will bill your insurance for both sick AND well visit. Your insurance might not pay for the combination visit; if this is the case, then you are responsible in paying the complete balance due. To avoid this, you will need to reschedule the Annual/Physical for another day.

Laboratory Services: Laboratory billing is separate to the physician bill you receive. We are not responsible for any laboratory billing issues that arise after the service provided. We can suggest labs as part of your annual checkup or medical conditions, but we do not provide any guarantee for its insurance coverage.

Labs & Imaging: All labs are reported to patients within 7 days. Your provider MUST SEE YOU within 1-2 weeks or sooner for all abnormal lab and imaging results so that our providers can assist with management and/or treatment plan.

Prescriptions: Your provider MUST SEE YOU prior to prescribing a new RX, refills on Antibiotics or Narcotics (Controlled medications) and changing your existing medication. NO controlled medication will be prescribed over the phone, out of State, after hours, or weekends. If you have not been seen your provider within the past 3 months and need a refill, you must schedule an appointment to see provider for your prescription refill. All medications have an appointment refill schedule that must be followed to ensure the safety of our patients. Please check with the staff if you have any questions about the refill schedule.

Referrals: Obtaining a referral from your insurance can take up to 72 hours or more. Please do not call from the specialist's office at the time of your appointment for a referral. An appointment is required to obtain a referral.
Medical Records: There is a $35 fee for printing of medical records for the first 20 pages, & 50 cents for each page thereafter. For Electronic records, the fee is $25 for 500 pages or less, and $50 for more than 500 pages.
No shows: If you do not show up and/or do not call us 24 hours in advance to cancel or re-schedule your appointment, we reserve the right to charge a $25 fee for the scheduled time that we were unable to give to other patients. After three consecutive no shows or rescheduling, we reserve the right to discharge you as our patient.
Disability/FMLA: An appointment is REQUIRED for all requests. There is a $35 fee for completing FMLA/Disability documents.

By signing below, I certify that I have read and understand the legal information and policies listed above.

Printed Name	Signature	Date

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MEDICAL HISTORY

Patient Name: _____ **Age:** _____

Please check off the following that apply to you.

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Chronic Pain
- ☐ Asthma
- ☐ COPD
- ☐ Pneumonia
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Blood Clot in Vein
- ☐ Rheumatological Disease
- ☐ Sleep Apnea
- ☐ Migraine
- ☐ Congenital Disease
- ☐ Diabetes
- ☐ Cancer
- If so, what kind? _____
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Seizures
- ☐ Insomnia
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ ADHD/ADD
- ☐ Arthritis
- ☐ STD
- ☐ Kidney Problems
- ☐ Mood Disorders
- ☐ Depression
- ☐ Anxiety
- ☐ Osteoporosis/Osteopenia
- ☐ Coronary Artery Disease
- ☐ SOB at rest
- ☐ SOB on exertion
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Palpitations
- ☐ Atrial Fibrillation
- ☐ Peripheral Arterial Disease
- ☐ Other: _____

Surgical Procedures / Hospitalizations ***Month/Year***

_____ _____
_____ _____
_____ _____
_____ _____

☐ NO Surgical Procedures ☐ NO hospitalizations

Social History

Do you smoke? ☐Yes ☐No ☐Former Smoker
If yes, how many times per day? _____
If a former smoker, when did you stop?_____
Do you use any other Tobacco products? ☐Yes ☐No
Do you drink alcohol? ☐Yes ☐No
If yes, how many drinks per week? _____
How often did you have 6 or more drinks? _____
Have you taken illegal drugs? ☐Yes ☐No
If yes, which ones? _____

Family History

Do any of the following conditions run in your family? If so, please list your relationship to them.

Mother's Age: _____ **Father's Age:** _____

Condition	Relationship	Alive?
☐Stroke		
☐Heart Attack/Disease		
☐ High Cholesterol		
☐ High Blood Pressure		
☐ Thyroid Disorder		
☐ Cancer		
Cancer Type? _____		
☐ Diabetes		
☐ Genetic Condition		
☐ Breast Disease		
☐ My family has NO health conditions.		

What year, if ever, did you last have the following?

_____ Routine Bloodwork
_____ Flu Vaccine
_____ Covid Vaccine
_____ Last Menstrual Cycle
_____ Pap Smear (Women 18+)
_____ Mammogram (Women 40+)
_____ Colonoscopy/Cologuard (45+)
_____ Prostate Screening (Men 50+)
_____ Shingles Vaccine (50 +)
_____ Bone Density Screening (65+)
_____Pneumonia Vaccine (65+)
_____Last Fall (65+)
_____Vasectomy (Men)
_____Hysterectomy (Women)
_____Diabetic Eye Exam

MEDICATION LIST **ALLERGIES**

Name of Medication	*Dose*	*Frequency*	*Food/Drug Name*	*Reaction*

☐ I am NOT on any medications ☐ I do NOT have any known allergies

CARD ON FILE AGREEMENT

Much like many other businesses such as a hotel or car rental agency, medical practices, attorneys, etc, Pioneer Medical Associates has a similar policy where we ask for a credit card which may be used at time of service or later to pay any balance that may be due on your account for your ease.

In Network Patients Your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. **Balances owed will be applied to the card on file**. These transferred amounts are outlined in the Explanation of Benefits (EOB) that is mailed to you by your insurance company. Your ability to dispute a charge or question your insurance company's payment determination will remain unchanged. All balances are still due at the time of service. The card on file will be charged accordingly on the day of your visit/procedure.

Self-Pay Patients All balances are due at the time of service. The card on file will be charged accordingly on the day of your visit/procedure.

No Show/ Late Reschedule fee policy:

We charge a fee for all missed appointments ("No Show") or Cancelled or Rescheduled in less than 24 hours. This fee will help us cover expenses incurred by staff and supplies in preparing for your visit.

- $ 25 for No show/ Reschedule.
- $ 50 for Zocdoc customers as a part of Zocdoc fees.

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express ☐ HSA

Name on Card (Print): _____ DOB: __/__/_____

Cardholder Relationship to Patient: _____

Credit Card Number: _____ Exp. Date: __/___

Acknowledgment :

I have read and understand the above consent and policy and I voluntarily agree to these terms and conditions.

Card Holder's Signature: _____ Date: _____

Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice? Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. The amount of time and effort to collect payments that will be saved will allow our office to focus more on patient care. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account? The insurance companies on average take approximately 2-3 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed with the card provided.

How do you safeguard the credit information you keep on file? We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our PCI and HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice

I always pay my bills on time. Why do I have to do this? The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be your provider. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions? Please contact our office directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a receipt/invoice bill by mail? Yes. You will receive a paid receipt/invoice for each transaction by mail or email based on your preference.