**CONFIDENTIAL INFORMATION**

Office Use Only: Account #: _____

**PATIENT INFORMATION**

Patient Name: _____ Nickname: _____

Mailing Address: _____City: _____ State: ____Zip: _____

Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Other

Social Security #: _____ Gender: ☐ Male ☐ Female

Home Phone#: _____Cell Phone#: _____ Work_____

Email _____ (for Patient Portal use): ☐ Personal ☐ Work

Referred By Dr. _____/Nurse: ☐ Primary Care ☐ Specialist

**PATIENT EMPLOYMENT**

Employment Status: ☐ Employed ☐ Retired ☐ Other:

Employer: Occupation: _____

**EMERGENCY CONTACT** Authorize to disclose personal info? ☐ Yes ☐ No ☐ Other

Name: _____Phone #: _____

Relationship to you: _____Other #: _____

**LEGAL HEALTH CARE DECISION MAKER**

Do you have an "Advanced Health Decision Maker" or "Power of Attorney"? ☐ Yes ☐ No

If so, who should we contact? _____Phone #: _____

Relationship to you: _____ Other #: _____

I have completed the above information to the best of my knowledge. I will notify the office of any changes in my health status or in any of the above information.

Signature of Patient (or Legal Guardian): _____

Today's Date: _____

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www.drmelona.com

Dr. Mel Ona

## FINANCIAL INFORMATION

**PRIMARY INSURANCE COMPANY**

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other

Insurance Company: _____Policy #: _____

Subscriber's Name: _____Subscriber's Birth Date: _____

Subscriber's Gender: ☐ Male ☐ Female Group #: _____

**SECONDARY INSURANCE COMPANY**

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other:

Insurance Company: _____Policy #: _____

Subscriber's Name: _____Subscriber's Birth Date: _____

Subscriber's Gender: ☐ Male ☐ Female Group #: _____

**OTHER INSURANCE COMPANY**

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other:

Insurance Company: _____Policy #: _____

Subscriber's Name: _____Subscriber's Birth Date: _____

Subscriber's Gender: ☐ Male ☐ Female Group #: _____

_____

**PERSON RESPONSIBLE FOR PATIENT'S MEDICAL BILLS [IF NOT THE PATIENT]**

Name: _____ Relationship to you: _____

Mailing Address: _____ City, State, Zip: _____

Date of Birth: _____Gender: ☐ Male ☐ Female

Home Phone#: _____Cell Phone#: _____Work Phone#: _____

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## OFFICE POLICY & FINANCIAL AGREEMENT

**OFFICE HOURS:**

Regular office hours are from 8:00 AM to 4:00 PM Monday through Friday excluding holidays. Office visits are by appointment only. We strongly believe in the value of your time and will do our best to keep scheduled appointments running smoothly. However, emergencies do occur and may cause a delay in your appointment.

**TELEPHONE CALLS:** Our front office staff handles incoming calls, which allows for the Physician or Physician Assistant to attend to their scheduled patients with minimum interruptions. They will transfer you to the appropriate staff member so you can leave a message for the Physician, Physician Assistant, or Medical Assistant. Your non-urgent calls will be responded to within two (2) business days. Prescription refills requests will be processed in three (3) business days.

**INSURANCES:** If you have insurance coverage, please understand that this is a contract between you and your insurance company. As a courtesy to you, we will help you receive your benefits by submitting medical claims for reimbursement, provided that we receive all the necessary and valid information.

*PLEASE NOTE THAT SOME SCREENING VISITS AND/OR PROCEDURES MAY NOT BE COVERED. CHECK WITH YOUR INSURANCE COMPANY PRIOR TO YOUR APPOINTMENT(S) BECAUSE YOU WILL RESPONSIBLE FOR PAYMENT IN FULL.*

**MISSED APPOINTMENTS**

Unless we receive a 24-hour notice of cancellation of your appointment, our policy is to charge for missed appointments at the rate of a normal office visit ($50.00 USD). To help better serve you, please keep your scheduled appointments. If you arrive late for your scheduled appointment without prior notice, we will reschedule your appointment at that time.

I, _____(print name), understand and agree to the above policies and that, regardless of my insurance status, I am responsible for any balance on my account for professional services rendered. I have completed the above financial information to the best of my knowledge. I will notify the office of any changes in my health status or in any of the above information. My signature below also authorizes the release of information necessary to process insurance claims to my insurance company(ies) and for payment to be made directly to any of the participating medical providers at Mel A Ona M.D. Inc.

Signature of Patient (or Legal Guardian): _____

Today's Date: _____

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**PATIENT HIPAA CONSENT FORM**

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I, understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Effective: 10/1/2019 ☐ Accepted ☐ Denied - Reason for denial:_____

Signature of Patient/Legal Representative Witness: _____

Printed Name: _____ Date: _____

If above is signed by a witness other than the patient:

*Patient Name printed (if not above): _____

*Patient's Birth Date: _____ *Relationship to Patient: _____

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