LEILA RHODES MD INC

INTERNAL MEDICINE

6525 LA JOLLA BLVD
LA JOLLA, CA 92037
Phone: 858-454-5557 Fax: 858-454-2223

PATIENT INFORMATION

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Sex: Male: _____ Female: _____ Date of Birth: _____

Social Security Number: _____ Occupation: _____

Employed By: _____ Work Number: _____

Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯

Religious/Spiritual Preference: _____ Preferred Language: _____

Race: _____ Ethnicity: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

EMERGENCY CONTACT

Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Subscriber/Policy Number: _____

Are you the subscriber for this policy? Yes: ◯ No: ◯

If No, Name of Subscriber: _____ Relationship to patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN#: _____

Secondary Insurance Name: _____

Subscriber/Policy Number: _____

Are you the subscriber for this policy? Yes: ◯ No: ◯

If No, Name of Subscriber: _____ Relationship to patient: _____

Subscriber's Date of Birth: _____ Subscriber's SSN#: _____

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MEDICAL HISTORY AND INFORMATION

Chief Complaint for Today's Visit: _____

Past Medical History: _____

_____

_____

_____

Past Surgical History: _____

_____

_____

_____

Family History: _____

_____

_____

_____

Allergies (including allergies to medications and those reactions): _____

_____

Medications (name, dose, frequency, and reason for taking, include over the counter vitamins or supplements):

_____

_____

_____

Height: _____ Weight: _____

Social History:

Tobacco: Yes: ◯ No: ◯ If yes, Current or Former Smoker: _____

Years Smoking: _____ How many packs per day/week/month: _____

Caffeinated Drinks: Yes: ◯ No: ◯ If yes, how many drinks per day: _____

Alcohol: Yes: ◯ No: ◯ If yes, how many per day/week/month: _____

Recreational Drug Use: Yes: ◯ No: ◯ If yes, Current or Former User: _____

List All Recreational Drugs Tried/Used: (specify whether drug use was experimental or long term use)

_____

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LEILA RHODES MD INC OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing Dr. Leila Rhodes Internal Medicine as your medical provider. We are committed to providing our patients with high quality medical care in a cost effective manner. To accomplish this, we depend on receiving prompt payment for our services. To keep you informed of our current office and financial policy, we ask that you read and sign our financial agreement prior to any treatment.

Payment: Dr. Leila Rhodes Internal Medicine provides a variety of payment methods. We accept cash, Visa, MasterCard and AMEX.

For patients with no medical insurance, Payment will be due at the time of service.

For patients with medical insurance: Please bring your insurance card(s) with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any service being rendered. The copay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

Past Due balances are required to be paid in full before you can be seen. If you are unable to pay your balance in full you will need to make prior arrangements with our billing dept.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. We do not send invoices until we have received a response from your insurance company. Any remaining balance is due upon receipt of that statement. After 3 notices, your bill will be sent to collections. If your account is sent to collections, a collection cost charge of 50% of the balance will be added to the balance owed. A payment plan can be arranged with our billing department upon request.

Patients are responsible for knowing the benefits covered by their insurance policies. Our services are documented to comply with federal law and will be billed accordingly. Verification that our providers are in network with your insurance plan is the patient's responsibility.

Patient Initial: _____

POLICY ON LABORATORY AND TEST RESULTS

As a holistic practice we encourage patient involvement / participation in your health. We like that our patients are aware of what laboratory tests were performed and the results of those tests.

To ensure this, it is our office policy that we recommend a visit with our provider to review and document that you have received and understand your results.

Patient Initial: _____

INSURANCE ACKNOWLEDGMENT

I acknowledge that I am aware that Leila Rhodes MD only accepts PPO (Preferred Provider Organization) and does not accept HMOs (Health maintenance organization). Furthermore, it is my responsibility to understand that any visits, labs and procedures may not be covered, depending on my deductible and plan coverage. This information can be obtained by calling my insurance.

Patient Initial: _____

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PATIENT FINANCIAL RESPONSIBILITY

I acknowledge full financial responsibility for services rendered by Dr. Leila Rhodes Internal Medicine. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles, and co-pays. I understand payment of co-pays is expected at the time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare/Medical insurance benefits be made on my behalf directly to Dr. Leila Rhodes Internal Medicine for any medical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges as outlined in office and financial policies guidelines.

Failure to promptly resolve your balance may result in collection action. If we have not received payment within 90 days of your first statement, you may receive a courtesy call and/or reminder letter regarding your balance. We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact our billing department at 858-454-5557 for assistance in the management of your account. Please note that making partial payment without prior approval by our billing department will not prevent further collection procedures, up to and including placement with an outside collection agency.

Patient Initial: _____

PATIENT CONSENT AND AUTHORIZATION

To the best of my knowledge, I have answered all questions truthfully and faithfully. I have read and fully understand the office and financial policies of LEILA RHODES MD INC. I understand that I am financially responsible, whether my insurance company pays or not, for all charges incurred by me. I further agree that in the event of nonpayment, I will bear the costs of collection and/or court costs and responsible legal fees should such actions be required. I agree that a photocopy of this authorization shall be as valid as the original.

Signature: _____ Date: _____

Parent Signature: (If patient is a minor): _____