SALCIDO
FAMILY MEDICINE

FRANCISO SALCIDO, MD - BOARD CERTIFIED

PATIENT REGISTRATION Date: _____

Patient's Full Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Number: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status (circle): M S D W

Social Security #: _____ Email address: _____

Race: _____ Ethnic Group: _____ Language: _____

Employer: _____

Employer's Phone # _____

Name of Spouse/Insured/Guardian: _____ Phone#: _____

Date of Birth: _____ Social Security #: _____

In case of emergency, contact: _____

Phone #: _____

Payment is requested at the time of service. Your policy and coverage is a contract between you and your insurance company. You are responsible for payment of the medical services regardless of the status of your claim.

Salcido Family Clinic issues monthly statements. The balance due for each account is payable upon receipt, unless otherwise specified. A 1-1/2 % per month (18% APR) service charge may be assessed on all amounts not paid by the 30th of the following month.

The Applicant agrees that all invoices and monthly statements are conclusive and accurate in all respects unless the Applicant notifies Salcido Family Clinic in writing within fifteen (15) days of receipt of the invoices or statements.

The Applicant agrees that if an account becomes past due, this account and any other amounts due to the clinic may become immediately due and payable. The Applicant further agrees that if any portion of an account is referred to an attorney or collection agency for collection, the undersigned agrees to all costs of collection and/or litigation including attorney's fees. If suit is brought, venue can be laid in a jurisdiction designated by Salcido Family Clinic. The Applicant also agrees to pay all existing and future service charges while the account is assigned to an attorney or collection agency. A charge of $ 30.00 will be assessed for all returned checks. _____Patient Initials

_____

Responsible Party Signature Date

Health Questionnaire

Your Name:_____Date of Birth: _____

Today's Date: _____ Last Doctor Seen: _____

Chief Complaint (describe briefly the problem which brings you to the doctor): _____

_____

_____

Prior Operations with Dates: _____

_____

Prior Medical Problems: _____

_____

_____

Current Medications: _____

_____

Drug Allergies: [] None _____ please initial the blank

[] Listed as follows: _____

_____

Family History (please provide any history of family health problems which may be significant): _____

_____

_____

_____

Social History: [] Never smoked [] Quit smoking as of _____ [] Still smoke

If you smoked or still smoke, how much?_____

How much alcohol do you consume in an average week? _____

Acknowledgment of Receipt of Notice of Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

I, _____(printed name of patient or personal representative), acknowledge that Salcido Family Medicine has provided a written copy of its Notice of Privacy Practices for Protected Health Information to:

_____ Myself (or personal representative)

And _____ (name of any other person you would want your information released to).

_____ _____

Signature of Patient or Personal Representative Date

_____ _____ _____

Printed Name Phone #

Relationship to Patient

To be completed by Salcido Family Medicine

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____ _____

Signature of Employee Date

_____

Printed Name and Job Function

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Missed Appointment Policy

At Salcido Family Medicine, your time is valued. Our physicians strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that our physicians can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

• It is your responsibility to provide us with a working telephone number and if available an email address to allow us to communicate important information, such as reminders of scheduled appointments. Having a valid telephone number and email address is truly important; please help us to maintain your records.

• **Effective September 1, 2013**, each missed appointment will be flagged and you may receive a notice that you have missed your appointment. In addition, your account may be assessed a $25 missed appointment fee. Please note that the fee will not be billed to your insurance.

• Accounts that accumulate three missed appointment fees may be dismissed from the practice.

• Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.

• If you arrive 20 minutes late for your scheduled appointment, without prior notification to our office, this may also be considered a "missed appointment". Please remember that communicating with our office is critical to us providing you with quality health care.

• We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office manager as soon as possible. We will waive the cancellation fee for this appointment as long as you do not have a history of cancellations. Our schedule fills up quickly, and this will allow other patients to fill those slots.

We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however due to patient emergencies or other unexpected incidents, our schedule may occasionally fall behind. If this is the case, we will make every attempt to let you know the status of our schedule.

Francisco Salcido, M.D.

Name of Patient Email address:

Signature of Patient

_____Date _____

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Prescription Policy

In order to serve our patients needs we have implemented the following prescription policy:

- It is the patient's responsibility to know what medications are covered under their insurance plan.
- During your office visit request enough meds to last until your next visit.
- Call your pharmacy **FIRST** for refills and request them to be sent **ELECTRONICALLY**. Electronic refills go directly to the physician and are filled throughout the day.
- Call your pharmacy **2** weeks before you run out of medicine.
- Avoid calling the office for refills on Fridays and weekends or holidays due to availability of providers. Please do not leave voice messages for prescriptions.
- Most offices are implementing a cost for refills and for medicine approvals. Please follow this policy to try to avoid this charge being implemented here.

Dr. Francisco Salcido

Name of Patient

Signature of Patient

_____Date _____