Carlos Campos, MD, MPH
189 E. Austin Street #102 New Braunfels, TX 78130

PATIENT HEALTH HISTORY

NAME		TODAY'S DATE
AGE	DATE OF BIRTH	PREVIOUS DOCTOR

REASON FOR TODAY'S VISIT

CHRONIC CONDITIONS & WHEN DIAGNOSED (DIABETES, HYPERTENSION, ETC)

MEDICATIONS: List medications you are currently taking including over-the counter drugs.

ALLERGIES: List all allergies you have to medications, food, etc.

SURGERIES, HOSPITALIZATIONS & EMERGENCY ROOM VISITS

YEAR:	HOSPITAL:	REASON FOR SURGERY, HOSPITALIZATION OR ER VISIT:

Have you ever had a blood transfusion? ___Yes ___ No
If yes, give approximate date:_______________

Do you have any infectious diseases: ___ Yes ___ No
(i.e. HIV, Hepatitis, etc)

HEALTH HABITS: Check which substance you use and describe how much and how often you use

___ Caffeine ____________________________
___ Tobacco ____________________________
___ Drugs ____________________________
___ Alcohol ____________________________
___ Other ____________________________

Date of Last: Colonoscopy ____________ Flu Shot ______________ Pneumonia shot ______________

Women Only: Menstrual Period _________ Papsmear _____________ Mammogram _________________
Number of Children: ______ Number of Pregnancies __________ Are you pregnant _______
Pregnancy complications if any including year:____

FAMILY HISTORY: Specify if you or any blood relatives have had any of the following (state relationship to you):

Arthritis/Gout ___________________ Asthma ___________________ Cancer ______________________
Diabetes _________________ Heart Disease/Stroke _______________ High Blood Pressure ___________
Kidney disease _________________ Osteoporosis _______________ Chemical dependency __________
Depression or psychological illness ___________________________ Thyroid ___________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my provider responsible or his employees responsible for any errors or omissions that I may have made in the completion of this form.

Signature Date

Carlos Campos, M.D., M.P.H.
189 E. Austi.. Street, Suite 102
New Braunfels, TX 78130

PATIENT REGISTRATION

NAME	MARITAL STATUS Single Married Divorced Widowed
ADDRESS	DATE OF BIRTH SEX M F
CITY STATE ZIP	RACE ETHNICITY (Example: German, Canadian, French etc.)
HOME PHONE# WORK OR CELL #	PERSON TO NOTIFY IN EMERGENCY RELATIONSHIP
PARENT/LEGAL GUARDIAN NAME (if patient is a minor)	EMERGENCY CONTACT PHONE #

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Please provide your current primary insurance card so we may keep a copy in your chart for our records and complete **all** of the following information so that we can file your insurance claims for you.	Please provide your current secondary insurance card so we may keep a copy in your chart for our records and complete **all** of the following information so that we can file your insurance claims for you.
NAME OF PRIMARY INSURANCE COMPANY	NAME OF SECONDARY INSURANCE COMPANY
ID # GROUP #	ID # GROUP #
NAME OF POLICYHOLDER	NAME OF POLICYHOLDER
ADDRESS OF POLICYHOLDER	ADDRESS OF POLICYHOLDER
CITY STATE ZIP	CITY STATE ZIP
POLICYHOLDER'S DATE OF BIRTH	POLICYHOLDER'S DATE OF BIRTH
EMPLOYER *(that insurance is covered by)*	EMPLOYER *(that insurance is covered by)*
POLICYHOLDER'S RELATIONSHIP TO PATIENT	POLICYHOLDER'S RELATIONSHIP TO PATIENT
I hereby authorize payment be made directly to Dr. Carlos Campos for surgical and/or medical benefits, if any, otherwise payable to for his services, realizing I am to pay for any non-covered services, co-pays, coinsurance and deductibles. I also hereby authorize Dr. Carlos Campos and/or his staff to release any information acquired in the course of my treatment necessary to process insurance claims and provide continuity of care with other providers he refers me to. ____________ ______ Signature of Patient or Legal Guardian Date	I hereby authorize payment be made directly to Dr. Carlos Campos for surgical and/or medical benefits, if any, otherwise payable to for his services, realizing I am to pay for any non-covered services, co-pays, coinsurance and deductibles. I also hereby authorize Dr. Carlos Campos and/or his staff to release any information acquired in the course of my treatment necessary to process insurance claims and provide continuity of care with other providers he refers me to. ____________ ______ Signature of Patient or Legal Guardian Date

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Dr. Campos and/or his staff will not release medical information to or discuss medical information with anyone except the following people listed below unless permission is given in writing. Also, <u>ONLY</u> the people listed below will be able to <u>pick ANYTHING up</u> for you from our office.

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

NOTICE OF PRIVACY PRACTICE: I hereby acknowledge that I have been presented with a copy of Dr. Carlos Campos' Notice of Privacy Practice and that I have read and understand my rights.

Signature of Patient or Legal Guardian if patient is a minor ____________________ Date ____________________

CARLOS CAMPOS, M.D., M.P.H.
FINANCIAL POLICY

Welcome to the office of Dr. Carlos Campos. In order for our staff to be able to deliver the quality of care that you are accustomed to; we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your co-payment at the time of your visit. If you have a balance after your insurance has processed a claim from a previous service, we will also ask for that payment. We accept cash, checks, Visa and MasterCard.
4. If we do not participate with your insurance company, you will be expected to make payment in full at the time service is rendered. We will, however, as a courtesy to you, file your claim with your insurance company.
5. If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and be reported to the credit bureau. All charges and/or fees assessed by the collection agency will be your responsibility.
6. Effective January 1, 2007, we reserve the right to assess a 1.50% monthly interest charge on any unpaid balance over 60 days old unless a payment agreement has been reached and is adhered to.
7. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have a secondary insurance, we will also bill that for you. If payment is not received from your secondary insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a secondary insurance, your portion (20% of amount allowed by Medicare) will be payable by you. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.
8. PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service – **<u>no exceptions.</u>** If your plan requires you to choose a primary care physician, it is **your** responsibility to make sure your insurance company has Dr. Campos as your PCP. If we are not your primary care physician, payment in full at the time of service will be expected because your insurance company will not cover your visit. If your plan requires you to have an authorization to see a specialist, you still need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. Request for referrals must be made at least 7 days prior to your visit to the specialist.
9. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay in full at the time of service.
10. "No show" or missed appointments: When an appointment is scheduled with the doctor and/or nurse, time is specifically allocated for you. When an appointment is not cancelled in advance, and the patient "no shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you. If **<u>two</u>** appointments are missed without a phone call, you may be charged a $25.00 fee payable directly by you. If **<u>three</u>** appointments are missed, you may be dismissed from the practice for non-compliance at our discretion.
11. Your insurance is a contract between you, your employer and the insurance company. **<u>We are not a party to that contract.</u>** It is very important that you understand the provisions of your policy and know what is and is not covered. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (830) 629-8161.

I have read and have a full understanding of the financial policy of Dr. Carlos Campos.

________________________________ __________________________

Signature of Patient or Legal Guardian if patient is a minor | Date

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Printed Name of Patient