BEAVER Medical Group
7541 US HWY 87 E, Suite #1
San Antonio, Texas 78263
(210) 648-9900

NEW PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE!

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DOB	SS#

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL

SEX (M,F)	RACE (CIRCLE ONE)	ETHNICITY (CIRCLE ONE)
	CAUCASIAN AFRICAN AMERICAN NATIVE AMERICAN ASIAN OTHER	HISPANIC OR LATINO NON HISPANIC OR LATINO OTHER

MARITAL STATUS (CIRCLE ONE)	LANGUAGE (CIRCLE ONE)
MARRIED DIVORCED SEPARATED WIDOWED SINGLE LONG TERM PARTNER	ENGLISH SPANISH FRENCH GERMAN JAPANESE MANDARIN OTHER

PATIENT'S EMPLOYER	EMPLOYER ADDRESS

BUSINESS PHONE	OCCUPATION	EMPLOYMENT STATUS (CIRCLE ONE)
		FULL-TIME PART-TIME RETIRED STUDENT

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE

HOW DID YOU HEAR ABOUT US?

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

LAST NAME	FIRST NAME	MI	DOB	SS#

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	MEMBER #	GROUP#

PLEASE CIRCLE ONE : PPO POS HMO HRA HSA CHOICE PLUSE HEALTH SELECT OTHER

POLICY HOLDER NAME	DOB	RELATIONSHIP TO INSURED	SS#

SECONDARY INSURANCE NAME	MEMBER #	GROUP#

POLICY HOLDER NAME	DOB	RELATIONSHIP TO INSURED	SS#

PHARMACY INFORMATION

NAME	ADDRESS	PHONE

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Beaver Medical Group for all insurance benefits, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services renedered on my behalf or my dependent.

I authorize the above provider and/or any provider or supplier of services at Beaver Medical Group to release any information required for securing the payment of benefits.

I authorize the use of this signature for all insurance submissions.

SIGNATURE OF RESPONSIBLE PARTY	DATE

PERSONAL HISTORY	Have you ever had any of the following? (please check appropriate box)							
	YES	NO		YES	NO		YES	NO
HEART DISEASE			HIGH BLOOD PRESSURE			ASTHMA		
ARTHRITIS			KIDNEY/URINARY DISEASE			STROKE		
CANCER			MIGRAINES			HIGH CHOLESTEROL		
ANXIETY			DIABETES			DEPRESSION		
BLOOD DISORDERS			SEASONAL ALLERGIES			THYROID DISORDERS		

OTHER MEDICAL CONDITIONS (PLEASE LIST):

FAMILY HISTORY	Do any blood relatives have any of the following? (please check appropriate box)						
	YES	NO	WHICH RELATIVE?		YES	NO	WHICH RELATIVE?
HEART DISEASE				DIABETES			
HIGH BLOOD PRESSURE				ASTHMA/ALLERGIES			
HIGH CHOLESTEROL				STROKE			
ANXIETY/DEPRESSION				BLEEDING DISORDERS			
CANCER				THYROID DISORDERS			

OTHER MEDICAL CONDITIONS (PLEASE LIST):

SURGICAL HISTORY			IMMUNIZATIONS		ALLERGIES	
SURGERY	YEAR	PHYSICIAN	NAME	YEAR	ALLERGEN	REACTION
			FLU			
			TETANUS			
			PNUEMONIA			
			MENINGOCCAL			

SOCIAL HISTORY							HEALTH MAINTENANCE		
	YES	NO		YES	NO	HOW MUCH?	EXAM	YEAR	RESULTS
DO YOU SMOKE?			DID YOU EVER SMOKE?				COLONOSCOPY		
DO YOU DRINK ALCOHOL?			DID YOU EVER DRINK?				MAMMOGRAM		
DO YOU USE DRUGS?			DID YOU EVER USE DRUGS?				CHOLESTEROL		

MEDICATIONS (PLEASE INCLUDE ALL SUPPLEMENTS AND OTC)			FOR WOMEN ONLY	
NAME	STRENGTH	HOW OFTEN?	AGE AT ONSET OF MENSTRUAL CYCLE?	
			DATE OF LAST CYCLE?	
			ARE YOUR CYCLES REGULAR?	
			DATE OF LAST PAP SMEAR?	
			PREGNANCIES - HOW MANY?	
			NUMBER OF CHILDREN?	
			FOR MEN ONLY	
			DATE OF LAST TESTICULAR EXAM?	
			DATE OF LAST PROSTATE EXAM?	
			ANY URINARY DIFFICULTIES?	
PLEASE SEE RECEPTIONIST IF A LONGER FORM IS NEEDED			ANY ERECTILE DYSFUNCTION?	

PATIENT SIGNATURE	DATE

NOTICE OF PRIVACY

I have reviewed Beaver Medical Group's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ☐ Yes ☐ No

Name of Patient | Signature of Patient or Legal Guardian | Relationship to Patient | Date

FINANCIAL POLICY

I have review Beaver Medical Group's Financial Policy, and I understand that the services I have elected to participate in implies a financial responsibility on my part. **I understand that as a courtesy, Beaver Medical Group will verify my coverage and bill my insurance on my behalf** but I am ultimately responsible for payment of my bill and any fees not covered by insurance. I also understand that payment is due at the time of service.

I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Beaver Medical Group, the full and entire amount of the bill incurred by me or the below named patient; or, if applicable any amount due after payment had been made by my insurance carrier.

Patient requested copy: ☐ Yes ☐ No

Name of Patient | Signature of Patient or Legal Guardian | Relationship to Patient | Date

AUTHORIZATION FOR RELEASE OF PRIVATE HEALTH INFORMATION (PHI)

***This gives the (representatives of Beaver Medical Group) the authorization to speak to your spouse, parent or significant other about your medical and/or financial information. Please DO NOT put N/A if you would like for us to be able to talk with someone other than yourself. This includes medication refills.**

I _____, date of birth _____, hereby authorization Beaver Medical Group to release my PHI to the following individual. This consent will remain in effect until Beaver Medical Group is otherwise notified by me in writing.

☐ Appointment Times ☐ Medical & Health Information ☐ Billing & Demographic Information ☐ All Information

Name of individual information may be released to | Relationship to patient

Name of Patient | Signature of Patient or Legal Guardian | Relationship to Patient | Date

ADVANCED DIRECTIVES

Advance directives are legal documents that allow you to convey your decisions about end of life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals. An Advance Directive tells how you feel about care intended to sustain life.

☐ I would like information regarding Advance Directives. ☐ I do not wish to have information provided to me at this time.

☐ I already have an Advance Directive. ☐ I do not have an Advance Directive

Name of Patient | Signature of Patient or Legal Guardian | Relationship to Patient | Date

Beaver Medical Group, PLLC would like to welcome you to our office. We appreciate the opportunity to serve you. The following information is provided for your benefit so that we may better serve you. Please read, initial and sign at the bottom.

_____ 1. **PAYMENTS:** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard, Discover or American Express. There will be a charge
For all non-sufficient fund/returned checks billed directly to you by our recovery agency.

_____ 2. **APPOINTMENT TIME:** We ask that our patients arrive for their appointment on time; this will facilitate our ability to see you as scheduled. Patients arriving past their appointment time may need to be rescheduled. **Please note that we strictly enforce a ($25.00/ $50.00 No Show Fee); depending on the type of appointment that is scheduled. This is enforced if you do not show up for your appointment or you do not cancel 24 hours prior to your appointment.**

_____3. **WEIGHT LOSS POLICY:** All ***weight loss*** services (Phentermine refill/ Lipo-b injections) are considered cosmetic and (***non-billable to insurance***). These appointments are separate from a sick visit appointment. For your convenience you may be seen by the provider for a ***weight loss*** visit at the same time as a sick visit (congestion, sinusitis, lab follow-up) but it will still be considered a ***separate (non-billable to insurance)*** visit and you will be charged at the rate **of ($85.00 for a New Weight Loss and $55.00 for an established Weight Loss patient). If you have been a previous weight loss patient but have not been seen for weight loss program for more 1 year you will be considered a New Weight Loss Patient.**

_____4. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone numbers or Insurance information as soon as possible.

_____ 5. **MEDICATION REFILL REQUESTS:** We request that you contact your pharmacy first. They will call our office with the necessary information to refill your medication. No refills will be done after hours. Please request refills 1 week prior to your running out. **Please allow 24 to 48 hours for your refill request to be processed.**

_____ 6. **LAB AND X-RAY RESULTS:** Please allow 7 – 10 days for results. A member of our staff will contact you as soon as we receive and review your results.

_____ 7. **INSURANCE VERIFICATION:** This office will verify your benefits to the best of our ability once you supply your correct insurance information. Verification of coverage **DOES NOT** mean that all services rendered will be covered during your visit; however, any uncovered services, supplies and/or treatments will be your responsibility to pay.
Please Note: If the services performed at Beaver Medical Group are not paid by your insurance due to information that has not been provided to our office by you (the patient) the balance will become that patients' responsibility. It is the patients' responsibility to keep our office informed of any changes in your insurance.

_____ 8. **REFERRALS TO SPECIALISTS:** Please allow our staff 7 – 10 days to process your referral. ***If you are unable to make a scheduled appointment with your specialist, it is your responsibility to reschedule.*** Please be advised that some insurance companies extend referrals for a certain period. If you cannot make it within your appointed time frame, there may be a charge for a repeat authorization.

_____ 9. **DRUG TESTING:** It is the policy of Beaver Medical Group that every new patient and/or anyone on a narcotic or antidepressant will be drug tested at the providers discretion. Drug testing refusal will result in dismissal from the practice.

_____10. **MEDICATION MANAGEMENT:** All patients on a medication management protocol must be seen by provider once Every 6 months; (i.e., diabetes, cholesterol, testosterone, hormones, COPD etc.

_____ 11. **NARCOTIC PAIN MEDICATION:** Our office will prescribe pain medication as needed for acute pain and only for a short duration of time. If the patient suffers from chronic pain and needs further observation for possible long-term use of prescription narcotics, we will refer the patient to a pain management center. We will not prescribe narcotic pain medication and controlled substances if they are obtained from multiple physicians and/or pharmacies. (**Every patient that we prescribe narcotic medication to must be seen by the provider every 3 months for follow-up and refills and is subject to a drug test at the provider's discretion).**

_____ 12. **FORMS:** We will be happy to fill out any forms and/or letters that the patient may require. However, there will be a charge per document up to $25.

_____ 13. **LABS** We collect lab specimens (blood) here in our office as a convenience to our patients; the fee for this is $15.00. If you do not want to pay the convenience fee, we will be happy to give you a requisition for your labs and you may utilize any facility of your choosing.

I, being a patient of Beaver Medical Group agree to the above policies as set forth by Beaver Medical Group.

Patient Name _____ **Signature** _____ **Date** _____