

Center for Adult & Family Medicine

your doctor for life

Cheryl Sarmiento, M.D.
Board Certified, Internal Medicine

Joanne Daniel-Saunders, M.D.
Board Certified, Internal Medicine

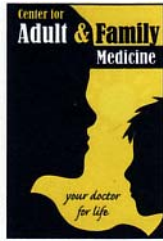
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Marcela V. Young, M.D.
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OUR INSURANCE FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

- ❑ If you do not have insurance coverage, payment is due at the time of service. We are required by your insurance company to collect your co-pay at the time of service. We accept cash, checks (as long as we have not had any returned items in your account) also Visa, MasterCard, Discover and American Express.
- ❑ Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60-day period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- ❑ We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay any balance your insurance company does not cover. We have waited for the 60-day period for insurance company to pay. The **balance that you may owe will be due as soon as** the insurance company notifies us of their intentions. They will either pay the claim, put to your deductible or co insurance or deny payment. We will file secondary claims twice. If insurance does not pay 20 days after second filing, patient will be billed for the balance.
- ❑ If you are insured by a plan **that we do not have a prior arrangement with**, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, **our charges for your care are due at the time of service**. The other option is that we will accept assignment so the check will come to our office. This does not mean that we will accept whatever the insurance company pays. You will be responsible for the balance.
- ❑ Not all insurance plans cover all services. In the event your insurance plan determines a service not to be covered, you will be responsible for the complete charge. **Payment is due upon receipt of a statement from our office.**



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OUR STATEMENT POLICIES

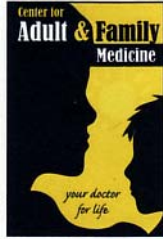
- We will hold your unpaid account in our office for 60 days only.
- If your account is not paid in full within this time, we will send your unpaid account to Collection Agency.
- All payment arrangements will then be made through them. They do report your outstanding account to the National Credit Bureaus.
- We do not want to do this to our patients; however, it is necessary for us to collect all money due our practice.
- We do have payment plans available if necessary.
- You will need to talk to the Billing Department or to Management and sign an agreement for payment.

I have read and understand the practice's financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by practice from time to time. **Sign and give to the receptionist.**

Signature of Patient (or responsible party, if minor)

Date

Please print the name of the Patient



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ATTENTION PATIENTS

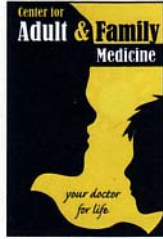
WE ARE REQUIRED TO UPDATE YOUR INFORMATION EVERY YEAR.

PLEASE BE PREPARED TO UPDATE YOUR RECORDS AND TO VERIFY INSURANCE INFORMATION AT EACH VISIT.

ALSO, WE ARE REQUIRED TO COLLECT ALL CO-PAYMENTS, NON-COVERED SERVICES AND DEDUCTIBLES AT TIME OF SERVICES. THESE PAYMENTS WILL BE COLLECTED AT THE FRONT DESK.

THANK YOU FOR YOUR COOPERATION IN THIS MATTER.

WE HAVE PAYMENT OPTIONS AVAILABLE IF NECESSARY. PLEASE ASK TO TALK TO OUR BILLING SPECIALIST.



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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

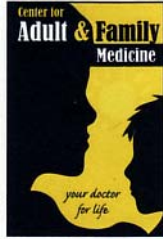
Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious health threat to your health and safety or the health of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request our practice communicate with you about your health and related issues in a manner or at a certain location. For instance, you may ask us to contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree with your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to (*Center For Adult and Family Medicine, Attention: Privacy Officer or (864) 627-1220*).



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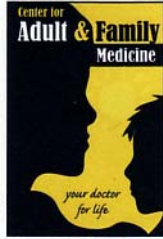
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4. You may ask us to amend your health information if you believe it is incorrect, incomplete, and as long as the information is kept by or for our practice. To request an amendment, submit in writing to (*Center For Adult and Family Medicine, Attention: Privacy Officer or (864) 627-1220*). You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact (*Center for Medicine, Attention: Privacy Officer or (864) 627-1220*). All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for other uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice, please contact (*Center For Adult and Family Medicine, Attention: Privacy Officer or (864) 627-1220*).



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Dear Patient,

Due to recent privacy regulations being enforced by the Government, our office can no longer discuss patient information with anyone other than the patient unless an authorization to release the information is signed and the name of the person stated is listed on the authorization below.

I _____ give the following person(s) the authority to receive information in regard to my account, lab results, referring doctor appointments, and/or my personal medical records.

Name	Relationship to patient	Description of information they can receive
------	-------------------------	---

You may leave the message on my voice mail or answering machine YES ___ NO ___

IF YOU ANSWER 'NO', PLEASE INSTRUCT US HOW YOU WANT THIS HANDLED!!

I have received, read and understand the patient information packet given to me regarding the office policies and protocol of Center For Adult and Family Medicine. Yes ___ No ___

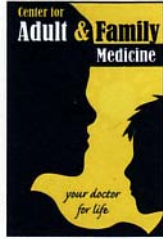
I have received the Privacy Policy for Center For Adult and Family Medicine and understand the purpose is to inform of my rights in regard to my PHI and also the ways in which Center For Adult and Family Medicine may use my protected health information. Yes ___ No ___

Signature

Date

I also understand I will be able to file a complaint with the privacy officer.

PLEASE PULL THIS PAGE OUT OF YOUR BOOK AND GIVE TO THE RECEPTIONIST FOR YOUR FILE. Thank you for your cooperation.



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PREVIOUS DOCTORS' OFFICE INFORMATION

DOCTOR'S NAME: _____

STREET ADDRESS: _____

CITY, STATE, AND ZIP CODE: _____

DR'S. OFFICE PHONE#: _____ **DR'S. OFFICE FAX #:** _____

YOU MUST FILL OUT ALL THE INFORMATION ABOVE. IF YOU DO NOT FILL ALL OF IT OUT, WE WILL NOT BE ABLE TO REQUEST YOUR MEDICAL RECORDS. THANK YOU.

RELEASE OF RECORDS

I hereby authorize and request you to release to Center For Adult and Family Medicine:

The complete medical records in regard to myself and/or dependents named below, concerning any past or present illness and/or treatment.

Patients Full Name: _____ Patients SS # _____

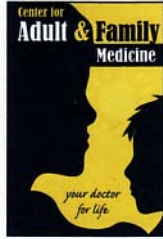
Patients Address: _____

City, State, Zip Code: _____

Signature: _____ Date: _____

Witness Signature: _____

Additional Patient Names if needed: _____



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PLEASE USE YOUR NAME AS IT IS LISTED ON ALL YOUR LEGAL DOCUMENTS

PATIENT INFORMATION

PATIENT'S LAST NAME: _____ **PT. NICKNAME:** _____

FIRST NAME: _____ M.I. : _____ HOME PHONE _____ CELL#: _____

STREET ADDRESS: _____ WORK PHONE#: _____ EXT#: _____

STREET ADDRESS 2 : _____ DATE OF BIRTH: _____ SOCIAL SEC. # : _____

CITY: _____ STATE: _____ ZIP CODE : _____ SEX(M/F) : _____ MARITAL STATUS: _____

EMPLOYED: YES NO / SCHOOL YES NO EMPLOYER/SCHOOL : _____

PATIENT ID INS CO: _____ PATIENT ID 2ND INS CO: _____

E-MAIL ADDRESS: _____ **(FOR OUR OFFICE USE ONLY!)**

PERSON TO NOTIFY _____ (RELATIVE OR FRIEND NOT RESIDING WITH YOU) PHONE #: _____

GUARANTOR'S FINANCIAL RESPONSIBILITY

LAST NAME: _____ FIRST NAME: _____ M.I. ____ AS ON INSURANCE CARD

FULL STREET ADDRESS: _____

HOME PHONE#: _____ WORK PHONE#: _____ CELL PHONE#: _____

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

NAME OF PRIMARY INSURANCE CO.: _____ PHONE _____ GP# _____

ADDRESS: _____

EMPLOYER _____ EFFECTIVE DATE: _____ INS ID# _____

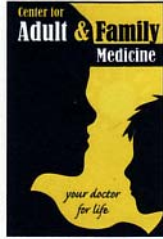
POLICYHOLDER NAME: _____ DOB _____ POLICYHOLDER'S SS# _____

NAME OF 2ND INSURANCE CO.: _____ PHONE _____ GP# _____

ADDRESS: _____

EMPLOYER _____ EFFECTIVE DATE: _____ INS ID# _____

POLICYHOLDER NAME: _____ DOB _____ POLICYHOLDER'S SS# _____



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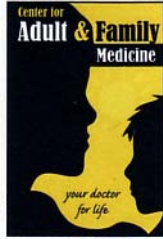
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PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE ABOVE NAMED PATIENT YES NO
2. I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS TO THE REFERRING AND FAMILY PHYSICIANS AND TO MY INSURANCE COMPANY, IF APPLICABLE. YES NO
3. I ALLOW FAX TRANSMITTAL OF MY MEDICAL RECORDS, IF NECESSARY YES NO
4. I ACKNOWLEDGE FULL FINANCIAL RESPONSIBILITY FOR SERVICES BY CAFM YES NO
5. I UNDERSTAND THAT CAFM HOLDS ACCT. BALANCES FOR 60 DAYS BEFORE IT IS TURNED OVER TO CBS COLLECTION AGENCY YES NO
6. I UNDERSTAND IT IS MY RESPONSIBILITY TO KNOW WHAT MY INSURANCE WILL COVER OR WILL NOT COVER. I DO NOT HOLD CAFM RESPONSIBLE FOR KNOWING THIS YES NO
7. I GIVE CAFM PERMISSION TO LEAVE APPT. REMINDERS ON MY ANS. MACHINE YES NO
8. I UNDERSTAND THAT PAYMENT OF CHARGES INCURRED IS DUE AT TIME OF SERVICE YES NO
9. I AUTHORIZE AND REQUEST THAT INS PAYMENTS BE MADE DIRECTLY TO CAFM SHOULD THEY ELECT TO RECEIVE SUCH PAYMENT YES NO
10. I HAVE READ AND UNDERSTAND THE ABOVE CONSENT NUMBERED 1 THROUGH 10. YES NO

DATE: _____ SIGNATURE _____



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Name: _____ D.O.B: _____

Reason to see the doctor today:

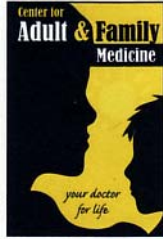
Prior surgeries and hospitalizations:

Have you ever been told you have/had:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer _____ | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Other _____ | | |

Current medications (include name, dose and strength):

Please list all allergies:



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Patient name: _____

Personal History:

- History of smoking? How long _____ How many packs a day _____ Year quit _____
 - History of drinking Alcohol ? How often? _____ Year quit _____
 - Illegal drug use ? Name of drug _____ How often _____ Year quit _____
 - Do you drink Caffeine? _____ Coffee ? _____ How much per day _____
 - How much sleep a night do you get ? _____
 - Service in the Military. What branch _____
 - Traveled or lived in another country? Where? _____
- Do you exercise regularly? Yes No If so, what type _____
- Years of education completed: _____ Occupation: _____
- Are you Married, Divorced, Widowed, Separated, or Single? _____
- Do you have any children? If so, how many? _____

Family History:

- High Blood Pressure High Cholesterol Diabetes
- Stroke Cancer _____
- Osteoporosis Heart Disease _____ Heart Attack
- Arthritis Thyroid Problems Asthma
- Fibromyalgia Renal Failure Depression/Anxiety
- Other _____

Health maintenance checklist, please include year:

- Physical Exam _____ Pelvic Exam _____ Breast Exam _____
- Colonoscopy _____ Mammogram _____ Prostate Exam _____
- PSA _____ Bone Density _____

Immunizations, please include year:

- Tetanus _____ TB Test _____ Influenza _____
- Measles, Mumps, Rubella _____ Hepatitis B _____, _____, _____
- Pneumococcal _____

Other treating physicians:

Patient signature: _____ Date: _____