Luna-Alexander Medical Management, LLC

Mario Luna, MD
Christopher Alexander, MD

PATIENT INFORMATION	PATIENT REGISTRATION FORM		
NAME (Last, First, Middle Initial)		EMERGENCY CONTACT NAME (Relationship to Patient)	
PRIMARY ADDRESS		CITY, STATE, ZIP	
CITY, STATE, ZIP		PHONE	☐ HOME ☐ CELL ☐ OTHER
SSN# (MEDI-MEDI)	BIRTHDATE / / Sex: M F	PRIMARY CARE PHYSICIAN	
PHONE	☐ HOME ☐ CELL ☐ OTHER	Address	PHONE
PHONE	☐ HOME ☐ CELL ☐ OTHER	PHARMACY NAME	
EMAIL		Address	PHONE

RESPONSIBLE PARTY/SUBSCRIBER INFORMATION (**If different than above**)			
NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE / /	SEX ☐ M ☐ F
PRIMARY ADDRESS	SECOND CONTACT BILLING ADDRESS (If Applicable)		
CITY, STATE, ZIP	CITY, STATE, ZIP		
PRIMARY CARE PHYSICIAN	RELATIONSHIP TO PATIENT		
PHONE	CITY, STATE, ZIP		

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY		POLICY #	CO-PAY AMT
NAME OF PRIMARY MEMBER INSURED	D.O.B.	GROUP #	DEDUCTIBLE
ADDRESS OF INSURANCE COMPANY		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)			
NAME OF INURANCE COMPANY		POLICY #	CO-PAY AMT
NAME OF PRIMARY MEMBER INSURED		GROUP #	DEDUCTIBLE
ADDRESS OF INSURANCE COMPANY		CO-PAY AMT	DEDUCTIBLE

REFERRAL SOURCE (How did you hear about our clinic?)

☐ INTERNET / WEBSITE ☐ FAMILY MEMBER ☐ HOSPITAL ☐ CURRENT PATIENT ☐ OTHER

WORK RELATED PERSONAL INJURY CLAIMS ONLY			
DATE OF ACCIDENT	BODY PART	EMPLOYER NAME	EMPLOYER CONTACT #
W/C INSURANCE CO. NAME		CLAIM #	PHONE #

I hereby assign the insurance benefits to which I am entitled, directly to Luna-Alexander Medical Management, LLC ,a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by Luna-Alexander Medical Management, LLC A phostat of this authorization is accepted with the same authority as original.

X _____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify Luna-Alexander Medical Management, LLC of any changes in information.

Patient History

Name: _____ **DOB**: _____ **Age**: _____ **Sex**: M F Other:

☐ Right-handed ☐ Left-handed **Height:** **Weight:** **Marital Status:** Single / Married / Divorced / Widowed

Reason For Visit

Reason for your Visit: _____ Date of Injury: _____

Did you have an injury? Explain: _____

Is this a Work Related Injury? ☒ No ☐ Yes

Location of Pain: _____

Are you limited in the following due to pain? ☐Work ☐Chores ☐Recreation ☐Exercise

☐Shopping ☐Other: _____

What treatments have you received? ☐Physical Therapy ☐Pool Therapy ☐Chiropractic Therapy

☐Steroid injections ☐Epidural Steroid injections (☐ Neck ☐ Lower Back) ☐Acupuncture

☐Surgery ☐Other:

Current Medications (Or attach list):

Name	Dose/ How Often	Name	Dose/ How Often

Are you taking any blood thinners? (ex: Plavix, Coumadin, other): _____

Medical History (Check from below or List any Medical Problems

☐ Diabetes (Is it insulin dependent?) Y / N		☐ Kidney Problems	☐ High Cholesterol	☐ Anemia	
☐ High Blood pressure	☐ Heart Attack	☐ Blackouts/Fainting	☐ Heart Disease	☐ Heart Stents	
☐ Bleeding Disorder	☐ Pacemaker	☐ Repeated Infections	☐ Arthritis	☐ COPD	
☐ GERD (Acid Reflux)	☐ Asthma	☐ Thyroid Disease	☐ Lung Disease	☐ Anxiety	
☐ Seasonal Allergies	☐ Depression	☐ Mental Illness	☐ Gout	☐	
☐ Cancer:		☐ Other:			

ALLERGIES TO MEDICATION (PLEASE LIST):	
ALLERGY TO LATEX: ☐ YES ☐ NO	

Past Surgeries (List approximate date and type of operation):

Operation	Date	Operation	Date

Hospitalizations (List dates and reason):

Has any blood relative had any of the following? PLEASE ENTER RELATIONSHIP

☐Arthritis		☐Tuberculosis		☐Migraines	
☐Anemia		☐Heart Disease		☐Diabetes	
☐Leukemia		☐Hypertension		☐Gout	
☐Bleeding Disorder		☐Kidney Disease		☐Cancers	
☐Repeated infections		☐Asthma		☐Ulcers	
☐Crippling infections		☐Allergies		☐Thyroid Prob	
☐Chronic lung disease		☐Mental Illness		☐Obesity	

Patient Signature _____ **Date** _____

Social Background

Employed? (What type of work): _____ ☐ Retired (When)? _____
Disabled? ☐ Yes: Why? _____
When did you last work? _____
Status: ☐ Single ☐Married ☐Divorced ☐Widowed
Living Situation: ☐Alone ☐Spouse ☐Significant Other ☐Family ☐Friends ☐Other:
Exercise: ☐Daily ☐1-3x per week ☐4-6x per week ☐Inactive:
Special Interest or hobbies (ie. Activities you participate in): _____

Tobacco Use

Do you smoke? ☐No ☐Yes If yes, how often: ☐Every day ☐Some days, but not every day ☐Other: _____
How many cigarettes a day? ☐5 or less ☐6-10 ☐11-20 ☐21-30 ☐31 or more ☐Other: _____
How soon after you wake up do you smoke your first cigarette? ☐within 5 min ☐6-30 min ☐31-60 min ☐after 60 min
Are you interested in quitting? ☒No ☐Yes
Former Smoker? ☐No ☒Yes If yes, how long has it been since you last smoked?
If 'former smoker': How many cigarettes a day? ☐Light (1-9 cigs/day) ☐Moderate (10-19 cigs a day ☐Heavy (20-39 cigs/day) ☐Other:

Drugs/Alcohol

Street Drugs? ☒No ☐Yes Substance: _____ How long? _____
Did you have a drink containing alcohol in the past year? ☐No ☐Yes
If 'Yes': How often did you have a drink containing alcohol in the past year?
☐Never ☐Monthly or less ☐2-4 times a month ☐2-3 times a week ☐4 or more times a week
If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
☐1-2 drinks ☐3-4 drinks ☐5-6 drinks ☐7-9 drinks ☐10 or more drinks
If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?
☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily
Do you smoke marijuana? ☒No ☐Yes

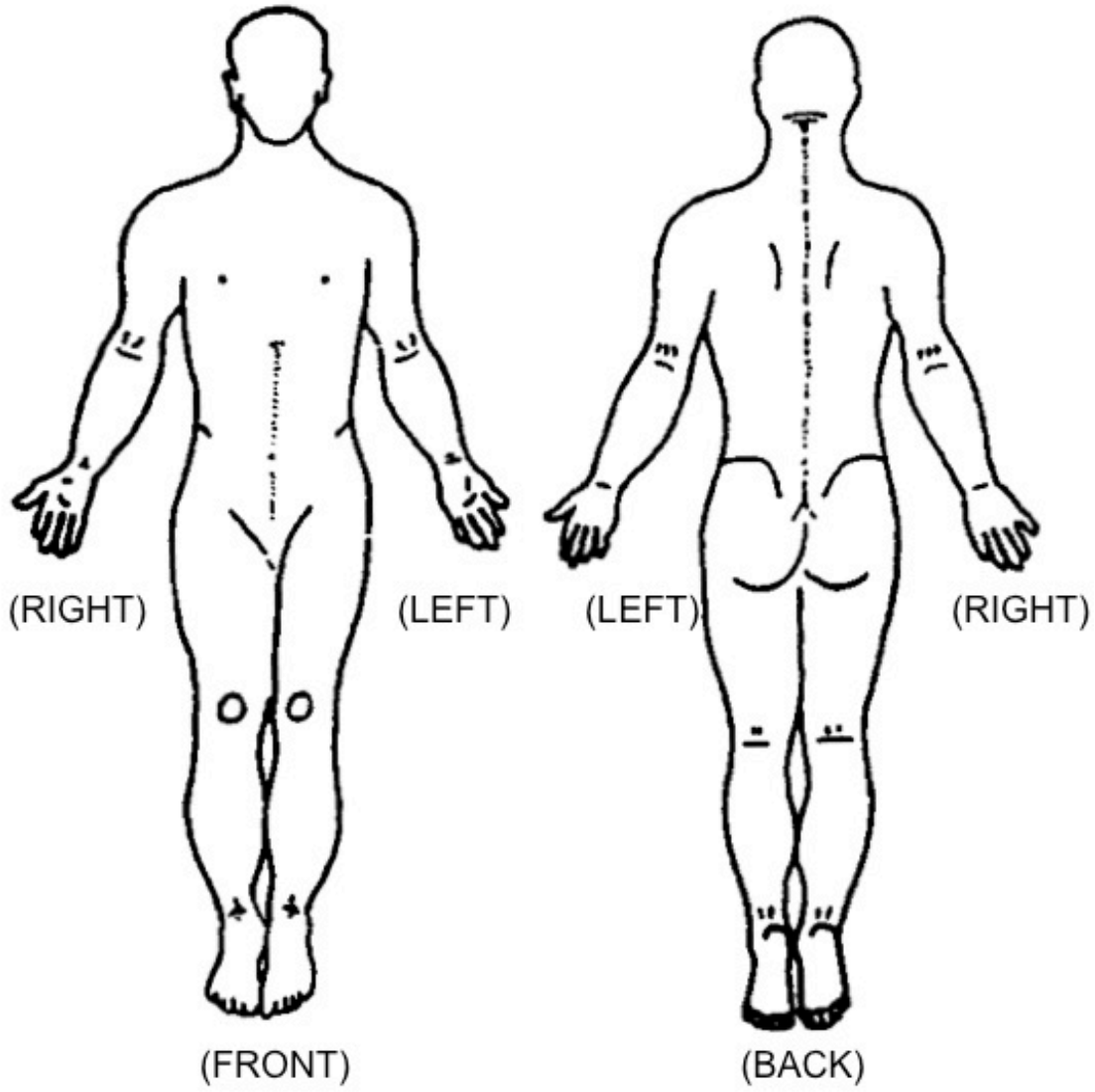
Workers Compensation

Work related injuries? ☒No ☐Yes Date of Injury: _____ Location: _____
If YES, please list employer and insurance company: _____
Employer: _____
Adjuster: _____
Insurance: _____
Is there any litigation pending: ☐No ☒Yes
Are you applying for disability benefits: ☒No ☐Yes

Patient Signature _____ **Date** _____

SHOW BY **MARKING** AND **DRAWING** ON THE BACK AND FRONT OF THE FIGURES BELOW WHERE YOU ARE HAVING MOST OF YOUR PAIN (ex: Mark "X" where you feel burning pain or "O" for numbness):

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING
^^^^	XXXX	OOOO	= = = =	/ / / /



Pain Scale (circle)											
No Pain	1	2	3	4	5	6	7	8	9	10	Worst Pain

Patient Signature **Date Completed**

MEDICAL RECORDS REQUEST

Patient Name: _____ Date of Birth: _____
Date(s) of Service Requested: _____
Provider or Department Requested: _____

I authorize the release of the following health information:

☐ Consultation	☐ History & Physical	☐ Lab Report	☐ Office Note
☐ ER Report	☐ X-ray Report	☐ Operative Report	☐ Other: _____
☐ Nurse's Note	☐ Physician Progress Note	☐ Discharge Summary	☐ Other: _____

Term: this authorization is effective immediately and will remain in effect for 1 year unless otherwise specified. I understand that all record requests require my authorization and that I may receive a copy of the authorization upon request.

Alternative expiration date:_____ Copy of authorization requested ☐

Unless you sign here, no information about alcohol/substance abuse, HIV/AIDS or mental health will be disclosed:

_____

Re-disclosure: I understand that once my health care provider discloses my health information to the recipient identified below, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my healthcare provider. Any revocation will be effective immediately upon my healthcare provider in reliance on this Authorization before the provider received my written notice of revocation.

Fees: Federal and state laws permit a fee to be charged for the copying of patient records. I understand that any applicable fees for copies of records must be paid before records are mailed or picked up.

Photocopy: A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Please forward records to:

_____
Patient Signature (Or legal guardian if patient is a minor)

_____
Date

_____
Physician Name/ Hospital Name/ Other

_____
Address

_____
City, State, Zip

_____
Phone Number

_____
Fax Number

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the current Notice of Privacy Practices and understand a current Notice of Privacy Practices is available at my appointments and at www.mariolunamd.com.

Patient Name: _____ Date of Birth: _____
Relationship to Patient if not "Self": _____

Signature: _____ Date: _____

Instructions for Communicating Personal Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Home	_____	Message: *Yes / No*
Work	_____	Message: *Yes / No*
Cell	_____	Message: *Yes / No*
Other	_____	Message: *Yes / No*
Email	_____	Message: *Yes / No*

My Protected Health Information may be communicated to (Write Name (ie. Relative, friend, etc…):

_____
_____
_____

Do not communicate my Protected Health information to (Write Name (ie. Relative, friend, etc…):

_____
_____
_____

Patient Initials: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date:_____

Reason:_____
_____

Employee Initials:_____

MEDICAL HEALTH COVERAGE

Financial Responsibility

- Insurance billing by the rendering providers billing company is provided as a courtesy
- Any charges not covered by health care benefits are the patient's responsibility.
- It is my responsibility to notify the office of any changes in my health care coverage.
- In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill, or balance of the bill, or balance of the bill, as determined by the office and/or my health care insurer if the submitted claims or any part of them are denied of payment.

Authorization of Release of Information

I authorize the release of medical or any other information to the health Care Financing Administration, my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Mario Luna, MD or Christopher Alexander, MD. A copy of this authorization will be sent to the health Care Financing Administration, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file.

My insurance remains the same from my last visit. ⬓ Yes ☐ No

OR

My new insurance is:_____

Primary Care Physician:_____

New Medical Group:_____

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

_____
Patient/Insured Name (Please Print)

_____ _____
Patient/Insured's Signature Date

ePRESCRIBE & MEDICATION HISTORY CONSENT FORM

ePrescribe Program

ePrescribing is a process for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions -**
  Gives the health care provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification -**
  Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions -**
  Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; adverse drug reactions; and duplicative therapy.

  The medication history information would include medications prescribed by your health care provider at Luna-Alexander Medical Management, LLC as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medication related to mental health conditions, venereal disease/sexually transmitted disease, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic disease, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at Luna-Alexander Medical Management, LLC many request / send and use your prescription medication history from other healthcare providers and / or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to the rendering providers at Luna-Alexander Medical Management, LLC to enroll in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature: _____ Date: _____

(Use if patient is a minor or otherwise has an authorized representative.)

Signature:_____ Date:_____

Cancellation Policy/No-Show Policy
For doctor appointments and Surgery

This is a statement that is acknowledging that you are obligated to pay fees in full. The rendering provider staff may verify your coverage at the time of your visit and bill your insurance carrier on your behalf as a courtesy. However, you are ultimately responsible for payment of your bill. By signing this agreement you are agreeing that you will pay any deductible, co-payment, co-insurance, and out of pocket or out of network expense as determined by your insurance plan. This includes any denials for "Not Medically Necessary" and or "Diagnosis does not meet Medical Coverage" denials you may receive on your Explanation of Benefit's (EOB). Many insurance companies have additional requirements or stipulations that may affect your coverage; it is your responsibility to understand these stipulations by contacting your insurance carrier and receiving acknowledgement of these potential stipulations. Also, all Office Visit Co-Pays are always due at the time of visit "no exceptions". In addition, you are responsible for potential Hospital or Ambulatory Surgery Center (ASC) procedures to be performed outside of Luna-Alexander Medical Management, LLC is covered with your insurance carrier or plan, as In-or-Out of Network and any additional Deductibles or Out of Pocket expenses that may be applied.

***LUNA-ALEXANDER MEDICAL MANAGEMENT, LLC* IS A NON BILLING ENTITY. ALL PAYMENTS OF BILLS WILL BE BILLED FROM AND PAID TO THE RENDERING PROVIDER, *MARIO LUNA, MD* OR *CHRISTOPHER ALEXANDER, MD*.** Please make all payments to your specific rendering provider, do not make any payments to *Luna-Alexander Medical Management LLC.* If you have any questions you may contact us at (951) 600-1795.

- **Cancellation/No-Show Policy for Doctor Appointment**

  We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours prior to the scheduled appointment or during the "automated reminder phone call" in advance, you will be charged a twenty five dollar ($25.00) fee; this will not be covered by your insurance company.**

- **Scheduled Appointments**

  We understand that delays can happen, however, we must try to keep the other patients and the physician on time. If a patient arrives 15 minutes past their scheduled time, we may have to reschedule the appointment.

- **Cancellation/No-Show policy for Surgery**

  Due to the large block time needed for surgery, last minute cancellations can cause problems and added expenses to the office. **If surgery is not cancelled at least 10 days in advance you will be charged ten percent (10%) of the cost of the procedure; this will not be covered by your insurance company.**

- **Account Balances**

  We will require that patients with self-pay balances pay their balance to zero (0) prior to receiving further services. Patients who have questions or would like to discuss a payment plan may call and select the option to speak to our billing office representative with whom can review their account.

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature: _____ Date: _____

(Use if patient is a minor or otherwise has an authorized representative.)

Signature:_____ Date:_____