Patient Name:

D.O.B.:

Date:

Today's Visit

Reason For Visit:

Labs – X-Ray – CT scan – MRI need to be Reviewed:

Refills needed:

Any Referral needed:

Patient Portal

To Activiate Your Patient Portal Please Fill In Information

Patient Name:

D.O.B:

Email:

Login URL is

https://mycw38.eclinicalweb.com/portal4352/jsp/login.jsp

Phone App is

HEALOW

health and online wellness

by: EclinicalWorks

Aging Center of Houston
Leena Chacko, M.D, PA

17320 RED OAK drive, Suite 260
Houston, Texas 77090.
Phone: 832-295-9829, Fax: 281- 840-5416

PATIENT REGISTRATION

Date: _____ Social Security #:_____

Patient: _____ DOB: ___/___/___

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Spouse: _____ DOB: ___/___/___ SS#: _____

Spouse's Employer: _____ Spouse Work Phone: _____

Patient's Cell Phone:_____ Spouse's Cell Phone:_____

Mother (if a minor): _____ *DOB:* ___/___/___ *SS#:* _____

Employer: _____ *Work /Cell Phone:* _____

Father (if a minor): _____ *DOB:* ___/___/___ *SS#:* _____

Employer: _____ *Work Phone:* _____

Address of Policy Holder/Guarantor's: _____

City: _____ *State:* _____ *Zip:* _____ *Home/Cell Phone:* _____

Children

Name: _____ Sex: M / F DOB: ___/___/___ SS#: _____

Name: _____ Sex: M / F DOB: ___/___/___ SS#: _____

Name: _____ Sex: M / F DOB: ___/___/___ SS#:_____

Emergency Contact Person: _____Relation_____Phone: _____

Insurance Information

Policy Holder/Guarantor's Name: _____ Relation to policy holder_____

Policy Holder's Social Security #:_____ *Policy Holder's* DOB: ___/___/___

Policy Holder's Employer: _____ Phone: _____

We file your insurance as a courtesy. It is to your advantage to become familiar with your health insurance benefits.

All Persons Covered Under This Policy:

_____ _____

_____ _____

How did you hear about us?_____

17320 RED OAK drive, Suite 250
Houston, Texas 77090.
Phone: 832-295-9829. Fax: 281-840-54.

AGING CENTER OF HOUSTON

Leena chacko MD PA

New Patient Record

Name: _____ Sex: M F

Today's Date: _____

Date of Birth: ___/___/___

Medical Illnesses (Please list any chronic medical illnesses or conditions.)

_____ _____

_____ _____

_____ _____

Current Medications
(Prescriptions, over the counter, Herbal medication)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Surgeries
(please list the year)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Current Allergies or Sensitivities

_____

_____

_____

List anything you are allergic to and describe how it affects you.

_____

_____

_____

Are you: Single / Married / Separated / Divorced / Widowed

Children: Girls___ Boys___ Work History: Are you currently employed? ☐ Yes ☐ No ☐ Homemaker ☐ Ret ☐ Disabled

Present type of work/employer: _____

Personal Habits	Never	Sometimes	Often
Regular Exercise (3 to 4x wk)			
Wear Seat Belt			
Brush Teeth (twice daily)			
Sleep Well			
Eat Balanced Meals			
Happy with Life			
Feel Lonely			
Feel Anxious/Nervous			
Use Drugs			
Smoke/Chew Tobacco			
Drink Alcohol			

Family Medical History

Relative	Age	Health Is Good	Poor	Deceased
Father	___	☐	☐	☐
Mother	___	☐	☐	☐
Brother	___	☐	☐	☐
Sister	___	☐	☐	☐
Spouse	___	☐	☐	☐
Child	___	☐	☐	☐

Cause(s) of Death: _____

_____

_____

If you (P) or a member of your family, Father (F), Mother (M), Sibling (Sib). Spouse (S), or Children (C), have had the following illnesses or problems list the appropriate initials:

Allergies _____
Asthma _____
Eczema, Rashes _____
Thyroid Problems _____
Lung Problems _____
Heart Diseases _____
Cholesterol Problem _____
High Blood Pressure _____
Phlebitis _____
Stomach/Intestinal Problems _____
Liver Diseases _____
Kidney Problems _____
Diabetes _____
Cancer _____
Anemia or Blood Diseases _____
Epilepsy _____
Mental Illness _____
Depression _____
Suicide Attempt _____
Alcohol/Drug Problem _____
Arthritis _____
Osteoporosis _____
Other _____

Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____
Date: _____ Initial: _____ Date: _____ Initial: _____ Date: _____ Initial: _____

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FINANCIAL POLICY

1. We will file insurance for any PPO, HMO, or other managed care plans with which we are under contract. All co-payments and/or deductibles must be paid at the time of service. It is your responsibility to make sure Dr. Leena Chacko is in your provider network and your PCP, if applicable. If we are not on contract with your insurance, payment is due at time of service.

2. We do accept assignment for Medicare and file all claims to Medicare. We do supplemental insurance billing for Medicare. Many times Medicare sends information to your supplemental carrier for processing.

3. There will be a thirty dollar ($30) fee assessed for any returned check.

4. Your insurance policy is a contract between you and your insurance company. It is impossible for our office staff to know all the details of each insurance plan. It is important that you know your coverage and your policy provisions. State law requires your insurance carrier to process your claim within 45 days. If they fail to do so, you will be responsible for paying all charges within 120 days from the date of service. _____

5. If your account is placed with a collection company for non-payment, there will be a collection service fee added to your account.

HMO and POS Patients Only

1. **Precertification of Emergency, Hospital Care** - HMO patients with Dr. Chacko as Primary Care Physician. We must be notified within 48 hours of any hospital admission or services that you have received outside of our office. Failure to do so may result in a reduction of benefits. We will not be responsible for any reduction of benefits and we will not retroactively approve any emergency care that we were not notified of within the allotted time frame. _____
2. **Referrals**: One of the physicians at Aging Center of Houston must see all patients whose insurance plan requires a referral to see a specialist. No phone referrals will be given. This is the policy of your insurance plan, not our office. Please allow three days for the referral to be processed by your insurance company. We cannot obtain retroactive referrals from your insurance company. _____

Initial the blanks above indicating you agree to payment and referral policy.

AUTHORIZATION

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Dr. Chacko. This assignment will remain in effect until revoked by me in writing. A photocopy of this policy will have the same validity as the original.

_____ _____

Patient's signature **Date**

Information Release Form

Leena Chacko MD PA

Patient Name: _____

___Yes ___No — I authorize AGING CENTER OF HOUSTON to Mail lab results to me.

___Yes ___No — I authorize AGING CENTER OF HOUSTON to release medical records to other requesting physicians

___Yes ___No — I authorize AGING CENTER OF HOUSTON to discuss medical issues, records, lab results and Diagnostic test to the name(s) listed below.

Please list the full name(s) and relationship to patient:

Name:_____ **Name:**_____

Relationship:_____ **Relationship:**_____

Signature:_____ **Date:**_____

17320 RED OAK drive, Suite 260
Houston, Texas 77090.
Phone: 832-295-9829, Fax: 281- 840-5416

Consent To Treat

Leena Chacko MD, PA

I (or my legal guardian) authorize Dr. Leena Chacko M.D, PA to provide medical care reasonable by today's standards.

Signature of Patient /Legal Guardian _____

Date _____

Medicare Patients Only:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medial or other information about me to release to the Center of Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand that I can revoke this authorization in writing at any time.

Signature as it appears on Medicare card:_____Date_____

Medicare Secondary Insurance (MEDIGAP Policies):

A MEDIGAP Policy is a supplemental policy that covers the remaining 20% that Medicare does not. If you have such a policy, we are required by Medicare to keep a second signature on file.

I request authorized MEDIGAP benefits be made on my behalf to AGING CENTER OF HOUSTON for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card:_____Date_____

Leena Chacko MD PA
17320 RED OAK DRIVE
SUITE 260
HOUSTON,TEXAS 77090

My pharmacy number is _____

I authorize Leena Chacko MD PA to send my Prescriptions to the pharmacy listed

PATIENT SIGNATURE _____
DATE: _____

SCREENING PAPERWORK

1. **DEPRESSION SCREEN DONE**
2. **FEMALE AGE 41-60 LAST MAMMOGRAM SCREEN _____**
    a. **IF NOT, ORDERS WERE GIVEN ON_____**
    b. **INITIAL IF REFUSE ORDERS FOR MAMMOGRAM_____**
3. **FEMALES AGE 21-64 LAST PAP SMEAR _____**
4. **FEMALES- DATE OF ANY BREAST SURGERY_____**
5. **FEMALES- DATE OF UTERUS OR OVARIAN SURGERY_____**
6. **ALL PATIENTS 50-75 LAST COLONSCOPY _____**
    a. **IF NOT, ORDERS WERE GIVEN ON_____**
    b. **INITIAL IF REFUSE ORDERS FOR COLONOSCOPY_____**
7. **DIABETIC PATIENT? YES___ NO____**
    a. **IF YES, LAST HA1C_____(ONCE EVERY 6 MONTHS)**
    b. **IF YES, LAST MICROALBUMIN_____(ONCE EVERY 6 MONTHS)**
8. **ALL PATIENTS- LAST LIPID PANEL (YEARLY) _____**
9. **PLEASE INDICATE WHEN THE FOLLOWING VACCINATIONS WERE DONE:**
    a. **FLU TEST _____(ONCE A YEAR)**
    b. **PNEUMOVAX_____(HIGH RISK PTS AND PTS 65 YEARS AND OLDER)**
    c. **TETANUS_____(ONCE EVERY 10 YEARS)**

NAME:
SIGNATURE:
DATE:

Leena Chacko M.D P.A
17320 Red Oak Dr Suite 260
HOUSTON TX 770902633
Ph: 832-295-9829 Fax:281-840-5416

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Total Score: _____

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately severe depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression

Leena Chacko, M.D.

New/Existing Patient Policy

Our relationship with you is one we value and feel that, as with any relationship, it is good to revisit our agreement and expectations of one another periodically. As regulatory and insurance coverage changes have occurred over recent years, The Aging Center has made some changes to our financial and administrative policies. We are hereby notifying you of recent changes and reminding you of other policies which may impact you, our patient and customer. We believe that this communication and these associated policies will help provide a better experience for you and will help expedite the check-in process. The following are policies which may affect you, our valued patient:

Deductibles, Coinsurance and Copays
Your insurance policy is a contract between you and your insurance carrier, and not one which The Aging Center has control of. Policy benefits/requirements vary greatly from one carrier/plan to another. It's important that you review and understand your insurance benefits because some services may not be covered. In addition, your health insurance plan mandates that you are financially responsible for all deductibles, coinsurance, co-pays and non-covered services. The Aging Center is contractually obligated to collect these fees and we are not able to waive them for any reason.

At the start of the New Year, most deductibles reset and, as employers and carriers strive to reduce overall healthcare costs by increasing "healthcare consumerism," most deductibles are on the rise. Since patients are increasingly becoming financially responsible for a larger portion of their medical charges, we need to make adjustments in how we receive payment for the services we provide. This is especially important when deductibles reset and we know that patients will be financially responsible for the majority of their charges. One change you'll notice this year is that we will be reviewing transactions from insurances and will be collecting applicable deductible and copay amounts at the time of service, rather than mailing you a bill.

Health Savings Account (HSA)
Many companies are now offering a Health Savings Account (HSA) in conjunction with their high-deductible health plans. The federal government created HSA's so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses. When you receive services at The Aging Center, you can use your HSA debit card to pay for out-of-pocket expenses such as copays and deductibles. All you need to do is present your HSA debit card for payment just as you would with a standard debit/credit card. To learn more about HSA's, please visit the IRS website or contact your employer's benefits coordinator.

Identification
At The Aging Center, we take your privacy and security seriously. In order to prevent fraud, it is important that we are able to properly identify our patients each time they are seen at The Aging Center or pick up prescriptions/health records. We ask that you please have your identification available, upon request, to confirm your identity and protect your information.

Insurance Cards

In order to process your medical claims accurately, we also ask that you bring your insurance card with you to each visit and have it available upon request. This provides us the opportunity to confirm the details and identify any errors that may cause your medical claim to be denied.

Third-Party Billing

It is sometimes necessary for THE AGING CENTER to acquire services from third-parties in order to meet some of your healthcare needs. The most common third-party services we use are laboratory and pathology testing. This means that you may receive a bill directly from a third-party for services provided as a part of your visit and care at THE AGING CENTER.

Medicare
Patients with Medicare coverage are asked to sign an Advanced Beneficiary Notice (ABN) when receiving certain services at THE AGING CENTER. We are required to have patients sign the ABN for services that may not be deemed medically necessary by Medicare; therefore, not covered. The ABN allows patients to know, in advance, what the medical service(s) may cost them if Medicare denies the claim.

Medicaid
One of the most common Medicaid questions we receive is "Which managed care plan should I choose?" Please contact the front office if you have Medicaid questions. Keep in mind that you required to bring your Medicaid card at each visit. We may have to reschedule your appointment if you arrive without your Medicaid card.

Prompt Pay
If you have no insurance, you may participate in our Prompt Pay Program, a discounted medical program. Through the Prompt pay patients that pay in full at the time of service are able to realize a discounted price by eliminating the administrative costs of billing an insurance and/or sending patient statements.

Under our Prompt Pay, patients are charged a flat fee of $98.00 per visit, payable by cash or debit/credit card. We do not accept checks as a method of payment for Prompt Pay fees. Should your visit become more complex and require significantly more time than a standard visit, your provider may charge an additional $50.00 at her discretion. Any additional services provided at your visit, such as laboratory services, will be charged in addition to the visit fee.

Signature _____ **Date** _____

Print Name _____ **Relationship to Patient** _____