Family and Aging Center

Leena Chacko M.D. PA

2255 E Mossy Oaks Drive, Suite 460
Spring, TX 77389
Phone: 281-362-5157 | Fax: 281-362-5162

PATIENT

Patient Name: _____

D.O.B.: _____

Date: _____

Reason For Visit

_____

_____

Labs – X-Ray – CT Scan – MRI Need to be Reviewed

_____

_____

Refills Needed

_____

_____

Any Referral Needed

_____

_____

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Activate Your Patient Portal

Please fill in the information below to set up online access to your records.

Patient Name: _____

D.O.B.: _____

Email: _____

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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:** _____

If Patient is a Minor

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? _____

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NEW PATIENT PAPERWORK

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New Patient Record

Name: _____ **Sex:** ☐ M ☐ F

Today's Date: _____

Date of Birth: _____

Medical Illnesses *(please list any chronic 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 ___ Currently employed?

☐ Yes ☐ No ☐ Homemaker ☐ Ret ☐ Disabled

Present type of work/employer: _____

Personal Habits	Never	Sometimes	Often
Regular Exercise (3-4x/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	☐	☐	☐

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

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

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, list 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	_____

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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 received outside of our office. Failure to do so may result in a reduction of benefits. We will not retroactively approve any emergency care that we were not notified of within the allotted time frame. Initial: _____
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. We cannot obtain retroactive referrals from your insurance company. Initial: _____

Please initial the blanks above to indicate agreement with the 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 _____

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Information Release Form

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 tests with the name(s) listed below.

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

Name: _____ **Name:** _____

Relationship: _____ **Relationship:** _____

Signature: _____ **Date:** _____

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Consent to Treat

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

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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 medical 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)

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:** _____

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Prescription / Pharmacy Authorization

My pharmacy number is: _____

I authorize Leena Chacko M.D. PA to send my prescriptions to the pharmacy listed above.

Patient Signature: _____

Date: _____

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PREVENTIVE CARE

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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 colonoscopy:** _____
   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 patients and patients 65 years and older)
   c. Tetanus: _____ (once every 10 years)

Completed By

Name: _____ **Date:** _____

Signature: _____

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DEPRESSION SCREENING

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 0	Several days 1	More than half the days 2	Nearly every day 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/speaking so slowly that others could have noticed – or the opposite, being fidgety/restless	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Total Score: _____

Interpretation

- ☐ Minimal Depression (1–4)
- ☐ Mild Depression (5–9)
- ☐ Moderate Depression (10–14)
- ☐ Moderately Severe Depression (15–19)
- ☐ Severe Depression (20–27)

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New / Existing Patient Policy

Our relationship with you is one we value, and as with any relationship, it is good to revisit our agreement and expectations 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 this communication will help provide a better experience and help expedite the check-in process. The following policies 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 controls. Policy benefits and requirements vary greatly from one carrier or plan to another. It's important that you review and understand your insurance benefits, since 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 is 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 responsible for a larger share of their medical charges, we are adjusting how we receive payment. One change you'll notice is that we will review transactions from insurances and collect applicable deductible and copay amounts at the time of service, rather than mailing a bill afterward.

Health Savings Account (HSA)

Many companies now offer a Health Savings Account (HSA) in conjunction with high-deductible health plans. The federal government created HSAs so individuals covered by such 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 — simply present it just as you would a standard debit or credit card. To learn more about HSAs, 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 or 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 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 you may receive a bill directly from a third party for services provided as 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 and therefore not covered. The ABN lets patients know, in advance, what the medical service(s) may cost if Medicare denies the claim.

Self Pay

If you have no insurance, self-pay charges are due at the time of service:

- **New Patient Visit:** $150.00
- **Follow-Up Visit:** $100.00

Signature _____ Date _____

Print Name _____ Relationship to Patient _____