

Date _____

Joshua Medical Group
Patient Information

Account# _____

Patient's Name _____ Date of Birth _____ Age _____

Address _____
Last First Middle City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ - _____ - _____ E-Mail _____ Gender _____ M _____ F

Please check appropriate Race and Ethnicity:Race: _____ American Indian/Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian or Pacific Islander
_____ White _____ Undetermined

Ethnicity: _____ Hispanic or Latino _____ Non-Hispanic or Latino _____ Other or Undetermined

Marital Status _____ Married _____ Single _____ Divorced _____ Widowed Spouse/Partner's Name _____

Employer _____ Address _____

Emergency Contact _____ Phone # _____

Guardian Name _____ Relationship to Patient _____

Guardian Address _____ Phone # _____ Work Phone # _____

Social Security # _____ Date of Birth _____

Primary Insurance Information

Name of Insurance _____

Policyholder Name _____

Birth Date _____ Effective Date _____

Social Security # _____

Insurance Phone # _____ Group# _____

ID # _____ Copay \$ _____

Secondary Insurance Information

Name of Insurance _____

Policyholder Name _____

Birth Date _____ Effective Date _____

Social Security # _____

Insurance Phone # _____ Group # _____

ID # _____ Copay \$ _____

Previous Insurance Plan _____ Is it still in effect? _____

Preferred Laboratory for Blood Work _____

How were you referred to our office? Please circle one.

Yellow Pages Friend Other Physician _____ Newspaper Other _____

We ask for payment at the time of services, unless other arrangements have been made (Insurance or special arrangements). I authorize the staff of Joshua Medical Group to perform necessary services during diagnosis and treatment. I have read and understood the above questions and statements.

Signature _____ Date _____

**Joshua Medical Group
Pediatric Health History**

Child's Name _____ **Age** _____ **Date Form Completed** _____

Birth History

Birthplace _____

Birth Date _____

Was pregnancy normal? _____

Was delivery normal? _____

Was baby full term? _____

Birth Weight _____

Birth Length _____

Any nursery problems? _____

Hospitalizations

When, Where, Why? _____

Surgery

When, Where, Why? _____

Growth and Development

Age when first:

Sat _____ Crawled _____

Rolled over _____ Walked _____

First tooth _____ Toilet trained _____

Serious Injuries

When, Where? _____

School History

Year in school _____

Grades Averaged _____

School Name _____

School Problems _____

Attends Special School or classes? _____

Discipline or behavior problems? _____

Ever seen by Psychologist, Speech Therapist? _____

Allergic Reactions

(Drugs, Hay Fever, Asthma, Eczema, Hives) _____

Family History

Mother: Living? _____ Age now _____ Health status _____

Father: Living? _____ Age now _____ Health status _____

Brothers/Sisters? _____ How many? _____ Ages _____ Healthy _____

Any family history of:

Diabetes _____ Allergies _____ Convulsions _____

Heart Disease _____ TB _____ Cancer _____

Past Medical History

Any problems with:

Sleeping? _____ Bedwetting? _____

Weight/Height? _____ Nail Biting? _____

Nightmares? _____

How long have you lived in this area? _____

Diet

Nursed or bottle fed? _____

Any colic problems? _____

Special diets? _____

Taking Vitamins or Fluoride? _____

Where did your family live prior to coming here? _____

Contagious Diseases (what age)

Measles _____

Mumps _____

Rubella (German measles) _____

Chicken Pox _____

Scarlet Fever _____

Other _____

General Survey

Has your child had any unusual problems with the following?:

Head _____

Eyes _____

Ears/Nose/Throat _____

Chest/Heart/Lungs _____

Stomach _____

Kidneys/Bladder/Urinary tract _____

Bones/Muscles/Joints _____

Skin _____

Blood _____

When was your child's last blood test? _____

When was your child's last urine test? _____

Immunizations (dates or ages given)

DPT _____

Polio _____

Measles/Mumps/Rubella- MMR _____

TB test _____

Other _____

Current Medications: _____

Any special comments about your child? _____

Child's previous Doctor _____

Person filling out this form _____

OUR FINANCIAL POLICY

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment. Therefore, if you have any questions or concerns about our payment policies, our staff will be happy to address them.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the physician.

- ☐ For Cash Patients: Payment for services is due at the time they are rendered. We accept cash, check and credit cards. (There is a \$25.00 additional charge for returned checks.)

I have read and understand Joshua Medical Group's Financial Policy.

PATIENT'S SIGNATURE _____ DATE _____

- ☐ For Patients with Medical Insurance:

1. As a courtesy, we will be happy to process your insurance claim for you. To properly bill your Insurance we require a legible copy of both sides of your Insurance cards, including the billing address (6 month updates require a new copy of your current Insurance card). *Appointments will be rescheduled if this information is not available.*
2. However, all charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all insurance contracts.
3. We accept assignment of insurance benefits which means your insurance company sends payment for our services directly to our office.
4. Co-payments are due at the time of treatment.
5. If your insurance company does not pay within a reasonable amount of time, and after we have made numerous attempts to collect, we will ask that you contact your insurance carrier and inquire as to why the claim has not been paid.
6. We try to work with all our patients regarding their balances. If, however, your account is assigned to our Collection Agency there will be a \$50.00 fee added to your balance for processing. You will receive a letter regarding your final notice giving you 10 days to pay your bill before your account is sent to collections and we add the process fee.

I, _____ hereby authorize _____
(Patients Name) (Name of Insurance Company)

To pay and hereby assign directly to Joshua Medical Group all benefits, if any, otherwise payable to me for his/her services as described. I understand that I am financially responsible for all charges incurred in the event that my insurance company does not make payment. I further acknowledge that any insurance benefits, when received by and paid to Joshua Medical Group will be credited to my account in accordance with the above said agreement. I authorize release of any medical information necessary to process all claims for Joshua Medical Group and/or its affiliated providers.

(Authorized signature of subscriber/patient) Date

We understand that temporary financial problems may affect timely payment on your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider

Joshua Medical Group

A FAMILY PRACTICE GROUP



TO ALL PATIENT'S WITH INSURANCE COVERAGE PLEASE READ AND SIGN

If you have insurance coverage, it is your responsibility to know the policy and guidelines of that company. What this means is:

- **You are responsible to know your deductible.**
- **You are to know your co-pay.**
- **Understand the type of coverage your insurance has.**
- **Telehealth appointments are treated as in-office visits, and your insurance will be billed for the services provided.**

With so many different insurance policies in effect it is virtually impossible for this office to know the details of every insurance policy. We will try to help you as much as possible...

- If your insurance denies your bill, you will be held liable for any charges.

We will be happy to answer any questions, or assist you in any way.

Thank you,

Gonzalo Martinez, MD

Patient Name

D.O.B

Patient Signature

Date

Joshua Medical Group

A FAMILY PRACTICE GROUP



THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information to be used or disclosed by us, whether electronically, paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal and protected health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use or disclose your medical records only for each of the following purposes: treatment, payment, and health care operations, and only to those entities that you approve.

Today's Date

I, _____, authorize Joshua Medical Group
First Name Last Name Date of Birth
to contact the following person(s) in regards to my protected health information.

Name	Relationship
Name	Relationship

INSTRUCTIONS:

Please leave the phone number(s) you would like to be contacted at and mark in the provided area whether or not we can leave detailed messages in the box next to the phone number.

Contact Numbers	Leave message with call back # ONLY	OK to leave detailed message
()		
()		

Patient Signature or
Legally Authorized:

24 Hour Cancellation & Rescheduling Policy

At Joshua Medical Group, your appointment is reserved especially for you. We value your time and ask for your cooperation in following our cancellation and rescheduling policy to ensure all patients receive the care they need in a timely manner.

Please note the following:

- We require at least 24 hours' notice for cancelling or rescheduling any appointment.
- Appointments that are missed, cancelled late, or rescheduled with less than 24 hours' notice will incur a \$25 fee.
- Repeated or multiple rescheduling may also result in a \$25 fee.

Missed appointments reduce availability for other patients who may need urgent care. It is your responsibility to remember your scheduled appointments.

As a courtesy, we will attempt to confirm your appointment by phone the day before. However, you are still responsible for keeping track of your appointment time, regardless of whether or not you receive a reminder call.

Thank you for your understanding and support in helping us provide timely care to all our patients.

Patient Information:

First Name _____ Last Name _____ Date of Birth _____

By signing below, you acknowledge that you have read and understand the above policy.

Signature of Patient or Authorized

Date