TOTAL CARE 280

AMY ILLESCAS, MD

Today's Date _____

Last Name _____ First Name _____

WHAT IS THE PURPOSE OF YOUR VISIT TODAY?

[ ] Annual Exam Only- I am here for my "Annual wellness examination" which will include a physical exam and may include a pap smear. I require no further testing or evaluation other than a renewal of my current birth control or hormone replacement therapy which have been prescribed here in the past if applicable.

[ ] Annual Exam & Other Reason- I am here for my "annual wellness examination" but I also have a problem, complaint or issue that I need to have evaluated/discussed, or I may require a new prescription or refill. I understand that my insurance will require a co-pay for any of these additional evaluations or where a prescription is given other than birth control or hormone replacement therapy.

[ ] Office Visit- I am not here for my "annual wellness examination" but for a specific problem, complaint, or recheck that I need evaluated, or I am requesting a new prescription. I understand that my insurance will require that co-pay be made for these services.

I currently have *of the following symptoms* ***Cough, Congestion, Sore throat, Fever, Vomiting****?*

Yes [ ] No [ ] (If unsure please go to your car and call.)

What is the most important issue we must discuss during our time here today?

1.) _____

Signed _____ Date_____

TOTAL CARE 280
AMY BENTLEY ILLESCAS, MD
10 MEADOWVIEW DR.
HOOVER, AL 35242

PATIENT INFORMATION

Date: _____ email address: (PRINT!) _____

Patient Name: _____

Date of Birth: _____Age: _____ Sex: M F Marital Status:_____

SS#: _____ Preferred Language: _____

Race: ___African Am ____Am Indian ____Asian ____Native Hawaiian ____White ____Other

Ethnicity: ____Hispanic/Latino _____ Non Hispanic/Latino

Phone: Home: _____ Work: _____ Cell: _____

PLEASE PROVIDE AT LEAST 2 TELEPHONE NUMBERS FOR US TO REACH YOU. FAILURE TO DO SO MAY RESULT IN DELAYS IN COMMUNICATING TEST RESULTS, ETC WITH YOU.

Address: _____

_____ZIP: _____

Occupation: _____

Employer: _____

Who referred you to us? _____

Primary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Secondary Insurance: _____

Policy #: _____

Group #: _____

Who is the insured: _____

Relationship to patient: _____

Insured's date of birth: _____

Pharmacy name: _____

Address: _____

Telephone Number: _____

PLEASE COMPLETE THIS PAGE & RETURN WITH INSURANCE CARD & DRIVER'S LICENSE – THEN COMPLETE ADDITIONAL PAGES

SOUTHERN CARE INTERNAL MEDICINE, PC
Amy L. Illescas, MD

The following people have my permission to obtain or have discussed with them my Protected Health Information (PHI):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

_____ I do not wish to list anyone. I do not want any information to be released.

I understand that you may be transmitting my medical records electronically to other doctors and authorize you to do so. If another party receives them in error, I absolve Total Care 280 (Amy Bentley Illescas, MD) of any and all liability to such submission of said records.

AUTHORIZATION TO LEAVE MESSAGES WITH OTHER PERSONS OR ON ANSWERING MACHINES/VOICE MAIL

I, the undersigned, authorize Southern Care Internal Medicine, PC to leave messages containing medical information, test results, doctor's recommendations on an answering machine/voice mail at the following phone number: _____

I the undersigned, authorize Southern Care Internal Medicine, PC to discuss my medical condition with the following person(s), which may include leaving a message with this person(s) regarding medical information, tests results or doctor's recommendations.

NAME	PHONE NUMBER	RELATIONSHIP

Patient Signature: _____ Date: _____

SOUTHERN CARE INTERNAL MEDICINE, PC
Amy Bentley Illescas, MD
10 MEADOWVIEW DR.
HOOVER, AL 35242
(205)547-2323

Patient Name _____

Patient's Date of Birth: _____

ASSIGNMENT AND RELEASE

I, the undersigned, authorize my insurance carrier/worker's compensation, including Medicare, to pay benefits directly to Southern Care Internal Medicine, PC and furthermore authorize the release of any and all information required to process my claim to my insurance carrier, including the Centers for Medicare and Medicaid Services (CMS).

I understand I am responsible for all non-covered services, deductibles and co-pays. In the event of a nonpayment or denial of payment by my insurance carrier/workers compensation carrier, I agree to pay all amounts due within 30 days. If I fail to pay the balance due on my account, I will assume all costs of collections, including reasonable attorney's fees as well as the legal rate of interest on the account until paid in full.

CONSENT FOR TREATMENT

Knowing that I (or the patient indicated on the top of this form) desire evaluation and/or treatment at Southern Care Internal Medicine, PC, I voluntarily consent to such care. I consent to routine diagnostic procedures, including but not limited to x-rays, blood draw, laboratory tests, administration of medication and to medical treatment by physicians and staff members of Southern Care Internal Medicine, PC. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of my examination or treatment at Southern Care Internal Medicine, PC. Patients at Southern Care Internal Medicine, PC will be treated regardless of race, color, age, national origin, disability or religion. Notwithstanding the above, Southern Care Internal Medicine, PC reserves the right to refuse care to any individual who may have an unpaid balance, exhibits rude or disruptive behavior or any other reason at the discretion of the office.

This consent shall remain in force until such time as it is specifically revoked.

_____ _____

Patient Name (please print) Date

_____ _____

Patient Signature/Guardian Witness