(Por favor escriba en letra de molde)

Su Nombre como aparece en su tarjeta de seguro médico: **Sexo:** **Masculino** **Femenino**

____ **Fecha de Nacimiento:** ________________

Domicilio: ____
Calle # de Apartamento Ciudad Estado Código Postal

Raza: ____________________ Etnicidad: ___________ Idioma: ______________

Núm. de Seguro Social: __ __ __ - __ __ - __ __ __ __ Estado Civil: Casado/a Soltero/a Viudo/a Divorciado/a

Núm. de teléfono de casa: ______________________ Núm. de teléfono celular: ____________________

Correo Electrónico: ____

Médico familiar: ____________________________ Núm. de teléfono: __________________________

¿Quién lo refirió a nuestra oficina? ________________ Núm. de teléfono: __________________________

Contacto de Emergencia: _______________________ Núm. de teléfono: __________________________

Relationship to Patient: ____

Nombre de la parte responsable: _________________ Relación al paciente: ____________________

Domicilio: _______________________________ Núm. de teléfono: ____________________________

Empleador: __________________________________ Núm. de teléfono: __________________________

Dirección: ____

¿ES EL MOTIVO DE SU VISITA POR UN ACCIDENTE DE TRABAJO? **SI** **NO**
¿ES EL MOTIVO DE SU VISITA POR UN ACCIDENTE AUTOMOVILÍSTICO? **SI** **NO**

POR FAVOR LLENE COMPLETAMENTE LA INFORMACIÓN DE SEGURO MÉDICO

SEGURO MÉDICO PRIMARIO: ______________________ Nombre del dueño de la póliza: ___________________

Núm. de Identificación: _____________ Núm. de Grupo: _______ Relación al paciente: ________

Núm. de Seguro Social del dueño de la póliza: ____________________

SEGURO MÉDICO SECUNDARIO: ___________________ Nombre del dueño de la póliza: ___________________

Núm. de Identificación: _____________ Núm. de Grupo: _______ Relación al paciente: ________

Núm. de Seguro Social del dueño de la póliza: ____________________

MEDICAMENTO ACTUAL:

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

ALERGIAS:
¿Es usted alérgico a algún medicamento? Si No

SI TIENE REACCIONES ALÉRGICAS a medicamentos, por favor enlistelos junto con su reacción:

Medicamento: Reacción:

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

¿TIENE CONDICIONES MÉDICAS?

____
____
____

FARMACIA:

Nombre: ____ Núm. de Teléono: ____________________

Dirección o intersecciones principales: ____

HISTORIAL SOCIAL: (Circule uno)

¿Fuma? Nunca Ex-Fumador Fumador Actual: ____ paquetes / cigarros por día

¿Consume Alcohol? Nunca Mensual Semanal Diario

Estatura: ________________ Peso: ___________________

¿Es usted paciente de cuidados paliativos? Si No

¿Es usted alérgico a Latex? Si No

¿Es usted paciente de una clínica para el control de dolor? Si No

****Si usted es paciente de una clínica para el control de dolor**, por favor proveanos la siguiente información:

Nombre de la clínica: ________________________________

Calles principales: ____

Número de teléfono: ______________________________________

____ ________________________

Firma del Paciente o Guardian **Fecha**

Johnny L. Serrano, D.O., F.A.C.O.S.
General Surgery
Board Certified
American Osteopathic Board of Surgery

CONDITIONS FOR TREATMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES AND PHOTOGRAPHS

The undersigned (hereinafter "Patient" which shall also include parents or legal guardians if the Patient is a minor or_lacks legal capacity and representatives of the Patient), consents to the procedures and services that may be performed by

Dr. Johnny Serrano and Precision Surgery Center, P.C.

(hereinafter referred to as the "Provider"). I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures and medical history and/or medical records for purposes of my diagnosis or treatment or for education or training programs conducted by the Provider. I understand that I have the right to request the cessation of recording or filming.

PERSONAL BELONGINGS

It is understood and agreed that the Provider shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value or of any value.

FINANCIAL AGREEMENT

The Patient agrees, whether he/she signs as agent or as Patient, that in consideration of the services to be rendered to the Patient, he/she hereby individually obligates him/herself to pay the charges of the Provider in accordance with the regular rates and terms of the Provider. If the provider is In-Network with your health plan, you agree to be responsible for any and all copayments, deductibles, co-insurances and non-covered services. If the practice is out-of-network with your Health Plan, you agree to be responsible for FULL Charges after all payments are received by the practice. Late payment of coinsurance, deductibles or patient

responsibility shall be subject to interest in the amount of 1% compounded per month (12% annual). A payment shall be deemed late for purposes of interest when it is not received by the 45th day after invoice is sent by Provider or his representative. Should the account be referred to an attorney or collection agency for collection, the Patient agrees to pay actual attorneys' fees and collection expenses plus interest at 10% annum. The Patient, his/her agent or representative, understand that medical bill submission to the Patient's Health Plan is done by the Provider's billing staff or authorized representatives as an accommodation to the Patient; that this does not in any way diminish or eliminate the Patient or his/her agent or representatives obligation to pay their account in full after services are rendered by the Provider. Pre-authorizations of services are any requires referrals are the responsibility of the patient.

CONSENT TO COMMUNICATION BY EMAIL AND TEXT

The Patient and his/her agent or representative hereby voluntarily provide their email address and cell telephone number_to the Provider and its authorized representatives, Patriot. The Patient and his/her agent or representative hereby authorizes the Provider and its authorized representatives Patriot to send and otherwise communicate with Patient or his/her agent or representative by email and text message with respect to the Patient's Medical Claims. The Patient and his/her agent or representative hereby voluntarily consent to such electronic communication as required by 15 USC 7001 and related state regulations and statutes. The Patient and his/her agent or representative may provide written notice to the Provider or its authorized representative Patriot to receive any communication on paper or non-electronic form. The Patient and his/her agent or representative agrees that his/her consent is continuous. However, the Patient and his/her agent or representative may terminate this consent in writing to the Provider or their authorized representative Patriot. There are no hardware or software requirements needed to receive email communication from the Provider or any of their authorized representatives including Patriot other than having an active email account and a cell phone that receives text messages from a vendor that provides such email accounts and texting options. The Provider and its authorized representatives Patriot agree that it will not sell, share, or rent patient email addresses, cell phone numbers or any other personal information collected based upon this consent. My email address is ______________________________ and my cell phone telephone number is __________________________________.

Patient/Guardian Signature

I have read and understand this patient consent agreement and I agree to its terms as a condition of medical treatment. I hereby acknowledge that at the beginning of my Treatment or services rendered by the Provider, I have been furnished with the Provider's Charity Care Policy, Policy for Collection of Patient Deductibles, Coinsurance and Other Patient Balances and this Conditions to Treatment document. I voluntarily sign this acknowledgement that I consent and agree to the Conditions of Treatment for services to be rendered by the Provider.

Agreed to by: ______________________________ / __________________________

(Patient signature) (Patient Printed Name)

Date: ___________________________

Agreed to by: ______________________________

(Guardian of Patient)

Date: ___________________________

Patient Initial: _____________

Johnny L. Serrano, D.O., F.A.C.O.S.
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Board Certified
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I hereby direct you to forward to Precision Surgery, LLC and their authorized representatives, The Patriot Group and The Force Law Firm, P.C., the following governing plan documents for the purpose of applicability of compliance with Client Protection Affordable Care Act:

1. **Summary Plan Description (SPD)**
2. **5500 Form (Plan Annual Report)**
3. **Certified Copy of Certificate for PPACA Grandfathered Plan.**

Please forward to the below address immediately:

The Patriot Group
247 West Montauk Highway – 2nd Floor
Lindenhurst, N.Y. 11757

DATED: ______________________________ ______________________________
Patient Name (Please Print)

____
Patient Signature

247 West Montauk Hwy
Lindenhurst, NY 11757
TEL: 844-705-0783/ 631-773-1178

Dear Patient:

We want to thank you for being patients of Dr. Serrano and Precision Surgery P.C. The purpose of this letter is to introduce our organization and explain how we are here to help you as patients of Dr. Johnny Serrano. We are the authorized medical billing vendor for Dr. Serrano and we have been contracted to send your medical claims for services rendered by Dr. Serrano to your health insurance company and to assist you in getting your health insurers to pay your medical claims.

We are here for you to assist you with any questions you might have about the medical billing process. Since Dr. Serrano is out of network with Aetna, United Healthcare Community Plan and Care1st. We ask that any correspondence and/or explanation of benefits you receive from your carrier regarding Dr. Johnny Serrano be immediately forwarded to us at the address listed below. In addition, if an appeal is necessary in order to compel full and complete settlement of Dr. Serrano's bill for services, then we will file an appeal on your behalf. We are leading and nationally recognized managed care appeals experts. We are skilled at getting your medical claims paid. ***Rest assured, you will not be asked to pay any of our fees. Dr. Serrano is responsible to compensate Patriot for our services.*** **We do ask and require your complete cooperation in our attempts to ascertain full payment from your health insurer of services rendered by Dr. Serrano. As part of the materials that you will or have received from office of Dr. Serrano and Precision Surgery, P.C., please complete the attached Assignment of Benefits and Collection Policy for Collection of Patient Deductibles, Coinsurance and Other Patient Balances.**

If you have any questions concerning your medical bills, or your health insurance claims, you may contact us as follows:

Jackie Brenes - Billing Manager
The Patriot Group
247 West Montauk Hwy
Lindenhurst, NY 11757
(631) 870-4048
jbrenes@patriotcompli.com

Thank you again for being a patient of Dr Serrano and Precision Surgery, P.C.

Sincerely,

Thomas J. Force
President

Johnny L. Serrano, D.O., F.A.C.O.S.
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BALANCE BILL POLICY – OUT-OF-NETWORK CLAIMS ONLY

Precision Surgery, LLC (hereinafter, the "provider") is an out-of-network substance abuse residential surgical practice in the State of Arizona. We are a non-participating provider with a few health plans meaning we have no contract with health plans to participate in their Network of Participating provider.

In many instances, the health plans do not pay the provider's charges in full. The provider understands that it has an obligation to bill their out-of-network patients the difference between the charge and all payments received. This is commonly referred to as a "Balance Bill". The Balance Bill amount owed by the patient in some cases is not properly stated on the health plan's EOBs and remittances.

The provider has created this Balance Bill Policy to comply with state and federal laws which require the Balance Bill of patients for out-of-network claims.

Before a patient is Balance Billed, the provider will exhaust administrative remedies with the health plan, if appeals are necessary or warranted. This usually involves sending one (1) and sometimes two (2) appeals or grievances.

Once administrative remedies are exhausted by the provider, and the provider feels confident that no further payment will be made by the health plan absent litigation, the provider will balance bill the patient the difference between the charge and all payment received.

Patients will be offered the provider's Financial Hardship Policy if they cannot pay the Balance Bill due to Financial Hardship.

Balance Bill letters will only be sent to out-of-network patients who have health plans that the provider does not participate with where the treatment center is out-of-network.

Balance Bill Letters will not be sent to patients who have health plans that the provider's participates with as in-network providers.

The statute of limitations for debt collection in Arizona is six (6) years for contracts in writing. Accordingly, the provider has six (6) years to collect the Balance Bill from its out-of-network patients.

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Professional Courtesy Policy

Precision Surgery LLC, (hereinafter, "provider") has adopted this policy for the care of professional clients. Professional courtesy is defined as delivering medical and other professional services by the provider free of charge, at a reduced rate, or where there is a waiver of insurance co-payments or deductibles, but only where the courtesy is provided to family members of the provider, current or former employees, and physician colleagues or their immediate family members, but only where such physicians work in the local community of the provider. The policy must be afforded to ALL physicians working in the local community and our policy is not discriminatory. This policy applies to professional courtesy afforded by the provider. When providing professional courtesy, the provider shall:

1. Never provide professional courtesy if the granting of professional courtesy might lead to direct or indirect future referrals to the treatment center because such courtesy would violate the federal Anti-Kickback, Stark Anti-Referral and possibly other state and federal statutes.

2. Never provide professional courtesy if the granting of professional courtesy might violate Stark Laws prohibiting the referral by a physician of Medicare clients, for items or services, when the physician has a financial relationship with the treatment center. However, the treatment center may grant professional courtesy for physicians in the local community and their immediate families, former or current employee and family members of treatment center owners where the courtesy granted is not linked in any way to referrals of clients or business to the treatment center or the treatment centers owners and provided that the services are the type the treatment center routinely provides.

3. Never provide professional courtesy if the treatment center owners have any business or other financial relationship with the client. Such courtesy could run afoul of Federal Stark Anti-Referral Laws.

4. Always ensure that the professional courtesy is made in a written document attached to the patient's chart.

5. Never offer professional courtesy if the patient is a member of any federal health program like Medicare or Medicaid, unless there is a good faith showing of financial need such that the client qualifies for discounted services under the provider’s charity care policy.

6. Never provide a professional courtesy for in-network patient unless the health plan is notified in writing.

7. Never submit an insurance claim to a health plan or insurer if professional courtesy is provided waiving part of a bill for services rendered, without a reduction of the charge reflecting the professional courtesy.