

Appt. Date: \_\_\_\_\_

### Patient History Sheet

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Prior Surgeries	Dates	Medical Illness	Onset
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____
_____	____/____/____	_____	____/____/____

Prior Hospital Visits	Dates	Allergies	Reaction
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

Current medication and dosages

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family History

Deceased or Alive

Year died/ Age/Cause of death

Mother \_\_\_\_\_

Father \_\_\_\_\_

Brother \_\_\_\_\_

Sister \_\_\_\_\_

Children \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Habits (amount and duration)      Prior

Smoking \_\_\_\_\_

Alcohol \_\_\_\_\_

Coffee \_\_\_\_\_

Other \_\_\_\_\_

Social History

Education \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_

Religious Preference \_\_\_\_\_

Other \_\_\_\_\_

Family member with:      Relationship

Cancer      Y or N      \_\_\_\_\_

Diabetes      Y or N      \_\_\_\_\_

Heart Disease      Y or N      \_\_\_\_\_

Hypertension      Y or N      \_\_\_\_\_

Liver Disease      Y or N      \_\_\_\_\_

Kidney Disease      Y or N      \_\_\_\_\_

Immunizations

Last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis B Vaccine \_\_\_\_\_

Pneumonia Vaccine \_\_\_\_\_

Childhood Vaccines \_\_\_\_\_

Transfusion History

Any history of prior transfusion? \_\_\_\_\_

If yes, when? \_\_\_\_\_



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## **Patient Acknowledgement of Financial Policy**

This document is designed to provide you with information regarding your responsibility in the billing process. As the patient you are ultimately financially responsible for the medical services you receive. You are responsible for providing accurate and up-to-date insurance information as well as your current address. In addition, it is your responsibility to know your insurance benefits, including coverage for office visits and annual wellness exams.

### **Annual Wellness Exams:**

- It is your responsibility to know what is covered during a physical exam/annual wellness exam.
- Your insurance will be billed for your physical exam, which typically does not require co-pay. If, however, your doctor addresses ANY other issues during your visit you will be required to pay co-pay, and an additional charge(s) will be billed to your insurance.

*Medical treatment for specific health conditions, on-going care, lab or other tests necessary to manage or treat a medical issue or health condition are considered diagnostic care or treatment, not preventive care.*

### **Self -Pay**

- If you do not have insurance coverage on the date of service, the entire cost will be collected at the time of service provided to you. We may also set up a payment plan. 50% of the total amount due must be paid at the time of service provided to you.

### **If you have medical insurance:**

- You are responsible **for co-pays**. Your insurance company requires us to collect co-payment at the time of service. Waive of co-payments may constitute fraud under state or federal law. Please help us in upholding the law by paying your co-payments at each visit.
- **Deductible payments:** Your insurance company requires you to meet a deductible before services are covered.
- It is our policy to send 3 statements for a past due balance. If payment is not made, a courtesy call will be made to try to make payment arrangements. If it is not resolved, the account will be sent to a collection agency.

### **Other charges:**

- You may incur other charges that are listed on the following page.
- You may be charged for Completion of Forms (i.e., Disability/Leave of Absence, and DMV forms) and Copying of Records. The fee will be set at the time of the request.
- Checks returned by a bank for any reason will be assessed as an additional \$30 charge. Any payments received after this point must be paid in cash, money order, or credit card.

Lastly, our office will not accept Worker's Compensation and Automobile Accident insurance. Therefore, we prefer you to seek a doctor who accepts Worker's Compensation and Automobile Accident insurance.

Your signature indicates that you have read and understand our financial policy and agree to abide by it.

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship (if applicable):** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

# Continuum of Financial Responsibility Policy

Due to rising costs in health care, we have implemented the following fees. Please take the time to review, sign, and date.

## FORMS – following fees apply if patient is requesting forms without an appointment. Medical Records

\$30 Leave of Absence/Family Leave (FMLA)

\$50 Medical Records

\$10 Short Term Disability

\$50-100 Third party requesting records

\$15 Other Third Party Correspondence

\$10 - \$30 Medical Certificate (e.g. Jury Duty, Gym Membership, Flexible Savings Accounts)

## **\$100 charge for ALL Missed appointments or late cancellations (We require a 24-hour cancelation)**

\$30 Bounced check fee

Your signature indicates that you have read and understand our financial policy and agree to abide by it.

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**SIGNATURE**

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**DATE**

### **Disclaimer for Non-Covered Services or Out-of-Network Services**

It is in your interest to know whether your physician is contracted with your insurance company. In addition, it is your responsibility to understand your benefits, deductibles, co-insurance, and co-pays prior to your visits.

The purpose of this document is to help you make an informed choice about whether or not you want to receive medical services, knowing that you might be personally financially responsible. Before you make a decision about your options, you should read this entire document carefully. If you still have questions, please don't hesitate to ask the staff or providers.

#### **Your insurance company may deny the claim for reasons listed below:**

Out of network provider

Non-Covered Services

A result of medical service(s) not being deemed a medical necessity by the insurance company.

Deductible

Policy has been terminated for the date the service was performed.

The fact that your insurance may not pay for a particular service(s) does not mean that you should not receive the service(s). There may be a good reason your doctor recommended this treatment.

By signing below, you are acknowledging that you've read and understood reasons your insurance may deny a claim.

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Signature of patient or person acting on patient's behalf

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Date

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

PATIENT

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: FEMALE  MALE

SOCIAL SECURITY NO.: \_\_\_\_\_ EMAIL: \_\_\_\_\_

CELL NO.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ WORK NO.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ HOME NO.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
APT/UNIT # CITY STATE ZIP CODE

MARITAL STATUS: SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED OTHER:

RACE (CIRCLE ONE): WHITE / AFRICAN AMERICAN / ASIAN / AMERICAN INDIAN / OTHER:

ETHNICITY (CIRCLE ONE): HISPANIC / NON-HISPANIC LANGUAGE (CIRCLE ONE): ENGLISH / SPANISH/FRENCH / OTHER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

NAME OF EMERGENCY CONTACT: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
FIRST LAST

RELATIONSHIP: \_\_\_\_\_ PHONE NO.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

INSURANCE INFORMATION

SUBSCRIBER'S NAME (IF DIFFERENT FROM PATIENT)

\_\_\_\_\_  
FIRST MIDDLE LAST

SUBSCRIBER ID: \_\_\_\_\_ CO - PAY: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE NO.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION (ONLY IF DIFFERENT FROM PATIENT)

RESPONSIBLE PARTY NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ HOME NO.: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ CELL NO.: (\_\_\_\_) \_\_\_\_\_

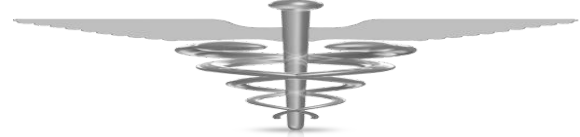
MAILING ADDRESS: \_\_\_\_\_  
APT/UNIT # CITY STATE ZIP CODE

**FINANCIAL DISCLOSURE** I hereby authorize and direct my insurance carrier(s) to issue payment to **Elizabeth Salada M.D.** for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize Dr. Elizabeth Salada to release all information necessary to secure payment of benefits.

PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Dr. Elizabeth Salada**  
15725 Pomerado Rd, Ste 214  
Poway, CA 92064



## Welcome to Dr. Salada Office

Thank you for choosing us as your primary care provider! Our team is committed to providing you with the highest quality of care, respect, knowledge, and compassion. Below are our office and financial policies. Please review, ask our staff any questions you may have, and acknowledge you understand our policies by initialing below.

### Practice Policies

**Effective October, 1<sup>ST</sup> 2025**

**OFFICE HOURS:** Monday-Friday 8 am – 5pm

**Phone Hours:** Monday – Friday 9 am – 4pm

Off at lunch 12pm – 1:30pm

#### **SCHEDULING**

Most of our initial visits for new patients are designed to allow you to establish care with us, assemble paperwork, order labs, refill prescriptions, and attend to urgent medical matters. Please arrive at least 15 minutes before your appointment to fill out paperwork. To meet your needs quickly, we may request that you see our family nurse practitioner (FNP) for this initial visit. After that you may be set up for a physical or follow-up appointment with your doctor. We do this to accommodate you quickly.

HMO patients must have Dr. Salada listed on the health insurance card to be seen by this office. If you arrive at the office and Dr. Salada is not listed as the Provider on the insurance card, you will be personally responsible for paying for the office visit at the time of the office visit and subsequently responsible for obtaining reimbursement from your health insurance company. Otherwise, you will not be seen and will be charged a cancellation fee of \$100 for a scheduled appointment.

#### **COMMUNICATING WITH US**

**Sharp App** allows you to schedule, reschedule or cancel appointments, send direct messages to your providers, review health information from your providers or hospital visit and more!

#### **PHYSICAL EXAM/WELLNESS EXAM**

It is your responsibility to know what is covered during a physical exam/annual wellness exam. Your insurance will be billed for your physical exam, which typically does not require co-pay. If, however, your doctor addresses ANY other issues during your visit you will be required to pay co-pay and an additional charge(s) will be billed to your insurance. **Medical treatment for specific health conditions, on-going care, lab or other tests necessary to manage or treat a medical issue or health condition are considered diagnostic care or treatment, not preventive care.** *(Please see attached form for additional information)*

#### **PREPARE FOR YOUR VISIT**

##### **1. WALK IN'S**

We do not take walk in patients unless there is a dire emergency, in which case, we recommend you go directly to the ER. We will do our best to triage your needs by phone. The one exception to this is urinary tract infections, for which we do encourage patients to call our office to schedule an appointment.

##### **2. VISIT AGENDA FORM**

We will ask you to complete our "Visit Agenda" form before each visit. This questionnaire will help us best address your needs and concerns which will be reviewed with you and the provider during your visit with us.

##### **3. ARRIVING LATE FOR AN APPOINTMENT**

If you are going to be late for an appointment, please call the office. Arriving more than 10 minutes late for an appointment will require that you reschedule the appointment. Additionally, you will be charged a \$100 fee for same day cancellation.

**4. NO-SHOW AND CANCELLATION FEE**

It is imperative that you give us 24-hour notice if you need to cancel or reschedule your appointment. **There is a \$100 fee for patients who do not show up for their appointment and/or have not called to cancel or reschedule the appointment within the 24-hour timeframe. You will receive a bill for it. If you no-show or do not cancel your appointment the day before you are scheduled. ( this is not covered by insurance this is the patient’s responsibility )**

**LAB RESULTS**

When you are given a lab slip during your office visit, your provider will specify how you will receive your results. Be sure you go to the laboratory that is required by your health insurance organization; otherwise, you will personally be responsible for this laboratory expense. Once we receive your lab results, one of the medical assistants will call you to either give you the results or schedule an appointment with you to discuss the results with one of the providers. If the medical assistant is not able to answer all your questions, if you would like more details on your results, or if you would like to discuss your results personally with the provider, you will need to schedule an appointment. If you do not receive your results, please contact the office; do not assume they are normal. Please allow at least one week for your provider to receive your lab results from the laboratory attending. On occasion, the lab will fail to send us the results, in which case your provider will not have been able to review them.

**Pharmacy**

For refill requests, please contact your pharmacy at least one week before you run out of medication and have them fax a refill request to our office. Once we receive the refill request from the pharmacy, your provider will sign and return the prescription refill to your pharmacy. You should allow 48 hours to have the medication in hand. If you need a “mail-in” prescription, please allow two weeks for your medication to arrive once you have mailed the prescriptions. It is best to schedule an appointment to allow a provider time to write these out. Patients needing certain drugs, such as narcotics, corticosteroids, and antibiotics may also require an appointment prior to their prescriptions being authorized. **If a medication needs prior authorization, requests may take anywhere from 1 to 2 weeks from the time the request is received in our office.**

**REFERRALS/ PRIOR AUTHORIZATIONS FOR DIAGNOSTIC TESTS**

If you have HMO insurance and require a referral to a specialist, you will need to see one of our medical providers for proper documentation. From that point, please allow several days for the referral to be processed. Most referrals are good for 90 – 180 days. If you need a follow-up visit with the specialist, another referral may be required, and it is up to you or your specialist to let us know.

**All prior authorization requests for diagnostic tests may take as long as 1 to 3 weeks, depending on your insurance company’s policies.** If diagnostic testing is urgently needed or considered emergent, we may have you be admitted to hospital.

Please print name here

Patient’s Name: \_\_\_\_\_

**Please Put Signature in The Box:**

*Please let us know how else we can be of service to you. We will do our best to provide you with excellent patient care.*



A Medical Corporation  
 Gateway Medical Center  
 15725 Pomerado Rd., Ste 214  
 Poway, Ca 92064  
 Ph: (858) 312-5492  
 Fax: (858) 312-5632

Patient Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Ph: \_\_\_\_\_

Office Providers: Dr. Elizabeth Salada | Christine Sullivan, FNP | Kelly Neil, FNP

**Patients' Authorization to Release Medical Information**

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form, I am designating the parties below with whom I wish Dr. Elizabeth Salada and staff members to be able to discuss my medical condition(s).

**I understand this form will be updated every calendar year.** If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform Dr. Elizabeth Salada and staff members in writing of my decision.

In accordance with the above, I \_\_\_\_\_, hereby authorize Dr. Elizabeth Salada and staff members to discuss with and release my medical information to the following individuals:

**( Please note anyone listed below is to be a relative and or family friend only )**

1. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

2. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

The below individuals are authorized to pick up any written prescriptions, medication samples or test results on my behalf. **ID must be always presented.**

1. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

2. Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded.

\_\_\_\_\_  
 Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_