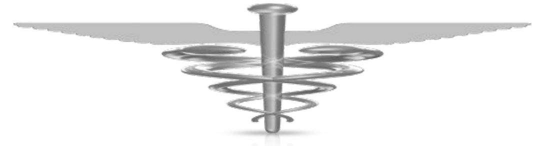
Dr. Elizabeth Salada
15725 Pomerado Rd, Ste 214
Poway, CA 92064



Welcome to Our 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 May 27, 2026
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.

COMMUNICATING WITH US

Athena Health through Patient portal (Athena Patient available on Play store , App Store) allows you to request 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.**

PREPARE FOR YOUR VISIT

1. SAME DAY APPOINTMENTS

We do not take walk in patients unless there is a dire emergency, in which case, we recommend you go directly to the ER or U.C. We will do our best to attend your needs by phone and schedule same or next day appointments.

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 provider and you during your visit.

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

On your visit, your provider will let you know if you need labs for your next appointment. Be sure to go to the laboratory contracted with your health insurance. Once we receive your lab results, an office member will call you to either give you the results or schedule an appointment with one of our providers to discuss them. If you have any questions about your results, 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. Occasionally, the lab may 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. You should allow 72hrs for your provider to approve the request. Patients needing refills on controlled medications such as narcotics will require an appointment. If a medication needs prior authorization, requests may take anywhere from 1 to 2 weeks from the time the requests is received in our office.

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.

☐ **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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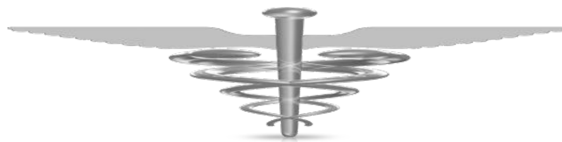

Patient Acknowledgement of Financial Policy

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 of 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.

$30 Leave of Absence/Family Leave (FMLA)

$25 Medical Records

$10 Short Term Disability

$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.

______________________________ ______________________

SIGNATURE **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.

______________________________ ______________________

Signature of patient or person acting on patient's behalf 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 EMERGENCYCONTACT: ____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: ______________________________