



HOAN PHO M.D.

INTERNAL MEDICINE | WELLNESS & AESTHETICS

NEW PATIENT PACKET

INTERNAL MEDICINE • WELLNESS • AESTHETICS

Dr. Hoan Pho

13150 NW Military Hwy Dr
San Antonio, TX 78231

Phone: (210) 541-4164

Fax: (210) 541-4168

Email: admin@hoanphomd.com

Website: www.hoanphomd.com

PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME (FIRST, MIDDLE, LAST)

DATE OF BIRTH

AGE

ADDRESS

CITY, STATE

ZIP

PRIMARY CONTACT # (HOME / CELL / WORK)

SECONDARY CONTACT # (HOME / CELL / WORK)

GENDER

SOCIAL SECURITY NUMBER

MARITAL STATUS

PERSONAL EMAIL

RACE

ETHNIC GROUP

PREFERRED LANGUAGE

OCCUPATION

EMPLOYER

PHONE

EMERGENCY CONTACT INFORMATION

1. NAME

RELATION

PHONE

2. NAME

RELATION

PHONE

INSURANCE INFORMATION

INSURANCE TYPE

☐ PPO ☐ HMO ☐ Medicare ☐ Self Pay

We are NOT contracted with HMO plans. Self-pay options are available.

PRIMARY INSURANCE NAME

PHONE #

ID #

GROUP

SUBSCRIBER'S NAME

SUBSCRIBER'S DOB

RELATIONSHIP TO PATIENT

EMPLOYER

SECONDARY INSURANCE NAME

PHONE #

ID #

GROUP

SUBSCRIBER'S NAME

SUBSCRIBER'S DOB

RELATIONSHIP TO PATIENT

EMPLOYER

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits from my insurance company to Dr. Hoan Pho and Integrative Health Solutions for services rendered. I authorize the release of any medical or other information necessary to process my medical insurance. I also request payment of government benefits to the party who accepts assignment, or to myself for non-assigned claims. The authorization applies to all occasions of service until it is revoked. The undersigned does hereby give procedures as maybe necessary for the best care of the patient. The undersigned also does hereby give authorization for Integrative Health Solutions to web-enable for personal email, thus allowing email notifications of passwords and patient portal notifications.

PAYMENT IS DUE AT THE TIME OF SERVICE

PATIENT SIGNATURE

DATE

MEDICATION INFORMATION

ALLERGIES

CURRENT MEDICATIONS

Please include Over The Counter medications and supplements:

MEDICATION	DOSE	FREQUENCY

MEDICATION	DOSE	FREQUENCY

PHARMACY INFORMATION

PRIMARY PHARMACY

PHONE

FAX

ADDRESS

CITY, STATE

ZIP

SECONDARY PHARMACY

PHONE

FAX

ADDRESS

CITY, STATE

ZIP

MAIL ORDER PHARMACY

PHONE

FAX

ADDRESS

CITY, STATE

ZIP

VOICE MAIL AUTHORIZATION

- ☐ I authorize Dr. Hoan Pho and his staff to leave voice mails about **diagnostic test results** pertaining to my health on the phone number listed below.
- ☐ I **DO NOT** authorize Dr. Hoan Pho and his staff to leave voice mails about diagnostic test results pertaining to my health on the phone number listed below.
- ☐ I authorize Dr. Hoan Pho and his staff to leave voice mails about **my appointment** on the phone number listed below.
- ☐ I **DO NOT** authorize Dr. Hoan Pho and his staff to leave voice mails about my appointment on the phone number listed below.

PHONE NUMBER

PRINT NAME

SIGNATURE

DATE

IMPORTANT COMMUNICATION NOTICE

Due to occasional issues with email and patient portal message delivery, patients are strongly encouraged to schedule an appointment to address any medical questions or concerns directly with a physician. This ensures timely communication and reduces the risk of missed or delayed messages regarding your health.

REACHING OUR OFFICE

Due to the volume of calls we receive, we kindly ask for your patience. If you are unable to reach us by phone, please leave a voicemail and allow **1-2 business days** for a return call. If you have not heard back within that time, please do not hesitate to call again.

Whether you need to schedule or reschedule an appointment, request a prescription refill, or have a billing question, email is a convenient way to reach us:

General Inquiries & Appointments: admin@hoanphomd.com

Billing Questions: billing.hoanphomd@gmail.com

We are committed to responding to all emails promptly.

FOLLOW-UP APPOINTMENTS

Your health is Dr. Pho's priority, and he will try to the best of his abilities to help you. As part of your treatment here, Dr. Pho may order lab testing, x-rays, diagnostic imaging, and biopsies, or send referrals to other specialists, studies, etc. As a patient, you must make sure that you have an appointment to review anything ordered by Dr. Pho either with him or the nurse practitioner.

If any appointments for lab testing, x-rays, diagnostic imaging, biopsies, or referrals to other specialists, studies, etc have been set up by our office and missed, it is your responsibility to reschedule.

By signing below, I am stating that I have read, understood, and agree to accept the office policies described above as set forth by Integrative Health Solutions. I also understand and agree that these policies may be amended by the practice at any time. The practice will make every effort to notify patients of any changes. We appreciate your loyalty to our practice and please know that we strive to offer the highest quality care to our patients.

PRINT NAME

SIGNATURE

DATE

FINANCIAL POLICY STATEMENT

Recent changes in healthcare have made it necessary for Integrative Health Solutions to implement changes in our Financial Policies. Our main goal is to provide quality medical care in the most cost-effective manner possible.

Payment will be expected at the time of service for all deductibles, co-insurances and co-pays. These fees are only an estimate determined by the information provided to us by your insurance company and not a guarantee of payment. If your insurance does not cover all the services provided (*example Labs, EKG*), you will be responsible for any balance due.

All current insurance information **MUST** be presented prior to services so that benefits can be verified and to facilitate the filing of your claim. We will also ask you to present a photo ID, this is required under Federal Law to prevent fraud.

Insurance benefits and coverage is a contract between you and your insurance company; thus, it is ultimately your responsibility to know what your benefits are. It is also patient's responsibility to notify the office at the time of service that you will be utilizing your preventive care benefits. Once a claim has been filed to the insurance, no changes will be made.

Patients will assume responsibility for all claims not paid by insurance within 90 days. As such, it is important that you respond promptly to any inquiries from your insurance or Integrative Health Solutions.

Please be advised if your insurance requires that you use specific labs outside of ours, it's the responsibility of the patient to notify the office **PRIOR** to the blood draw. The office will gladly issue you a written request for labs to be drawn elsewhere. If you **DO NOT** notify the office prior to your blood being drawn, all labs will be patients' responsibility. We do partner with certain labs and will always try our best to send to labs that are covered by your insurance. We will make an effort to code for labs in order for insurance to cover, but at times if the insurance doesn't cover a cost it will be the patient's responsibility.

Integrative Health Solutions will make every effort to acquire accurate insurance verification from your insurance. As a service to you we will file your claims to the insurance you have provided. Should the information provided be invalid or expired, you will be responsible for payment. Should any overpayment occur, Integrative Health Solutions will directly issue a refund or post as credit.

Integrative Health Solutions will file claims to no more than two insurance companies. Any additional filings will be patient responsibility.

Integrative Health Solutions will file a claim at least twice. If we have not heard from insurance within 90 days, we will send the bill to you and it will be your responsibility to contact your insurance and assume payment. State Law requires insurance companies to pay most claims within 30-45 days of being submitted.

Our goal is to assist you in receiving the coverage to which you are entitled. To that end Integrative Health Solutions take's great are in filing claims promptly (usually within 48 hours) and accurately, with the necessary codes for services rendered.

Please notify the office of appointment cancellations at least 24 hours in advance. Otherwise a **NO SHOW FEE of \$75** will be charged. If you have questions, please ask office staff.

There will be a fee of \$35 for any forms filled out or signed by Dr. Pho. Payment for the forms filled out or signed is due at the time you retrieve the completed forms.

TREATMENT OVER THE PHONE, AFTER HOURS CALLS AND REFILL CHARGES:

This notice serves as an acknowledgement that our office has a policy regarding Physician phone calls, treatment(s) over the phone and prescribing refills after hours. These policies are to help our office run efficiently while maintaining a high level of quality care to our valued patients.

PRESCRIPTION REFILLS AFTER HOURS: We ask that you allow 48 hours for refills during regular weekday hours. After hours request will take additional time. If you are needing a refill outside of our normal business hours, there will be a charge of \$50. This will not be billed to any third party and will be the patient's sole responsibility. Routine Prescriptions should be filled by your personal physician. Prescriptions written by another doctor or specialist should be refilled by that original physician unless expressly allowed by your physician at Integrative Health Solutions.

TREATMENT OVER THE PHONE: We strongly encourage you to be seen and not treated over the phone. In the event that extenuating circumstances prevents you from being evaluated, we can safely treat you over the phone. A charge will be billed for the services and will range from \$50-\$100 based on the complexity of the issues being discussed. This will not be billed to any third party and will be the patient's sole responsibility. The physician on call after office hours will determine if it is safe to treat over the phone or if you need to go to the emergency room and also determine if you can wait to be seen during regular office hours.

MEDICAL RECORDS RELEASE AND BILLING HISTORY FEES:

There is a fee for release of medical records of \$25 for the first 20 pages and 50¢ per page thereafter. Records will be released within 14 business days of written request as long s the fee has been paid. Records will not be release without payment. Billing history fee is \$15.

There is a \$45 charge for any check returned as insufficient funds.

NO SHOW FEE	AFTER HOURS REFILL	RETURNED CHECK	FORM COMPLETION
\$75	\$50	\$45	\$35

By signing below, I am stating that I have read, understood and agree to accept the office Financial Policies described above as set forth by Integrative Health Solutions. I also understand and agree that these policies may be amended by the practice at any time. The practice will make ever effort to notify patients of any changes. We appreciate your loyalty to our practice and please know that we strive to offer the highest quality care to our patients.

PRINT NAME

SIGNATURE

DATE

Policies effective 3/24/2020

IMMUNIZATION RECORD

Please provide the date(s) you received the following vaccines:

VACCINE	1ST DOSE	2ND DOSE	3RD DOSE
Flu			
COVID-19			
TDAP			
HPV			
Shingles			
Pneumococcal polysaccharide vaccine (PPSV23)			
Pneumococcal conjugate vaccine (PCV13)			
Hepatitis B			
MMR (Measles, Mumps, & Rubella)			
Varicella (Chickenpox)			
Meningococcal			

REVIEW OF SYSTEMS CHECKLIST

Please put a check mark by any symptoms that you have had recently. Please check "none" if you have not noticed any of the symptoms listed in that category.

CARDIOVASCULAR ☐ Chest pain ☐ Shortness of breath ☐ Swelling of the feet ☐ Racing Pulse ☐ Irregular heart beat ☐ Is your blood pressure under control? ☐ Yes ☐ No ☐ Unsure ☐ None CONSTITUTIONAL ☐ Fever ☐ Weight loss ☐ Fatigue ☐ Loss of Appetite ☐ Chills ☐ Night Sweats ☐ Poor appetite ☐ None ENDOCRINE ☐ Excess thirst ☐ Excessive urination ☐ Heat Intolerance ☐ Cold Intolerance ☐ Hair loss ☐ Dry skin ☐ Is your blood sugar under control? ☐ Yes ☐ No ☐ Unsure ☐ None	GASTROINTESTINAL ☐ Abdominal pain ☐ Nausea ☐ Diarrhea ☐ Bloody stools ☐ Stomach Ulcers ☐ Constipation ☐ Trouble Swallowing ☐ Jaundice/yellow skin ☐ None GENITOURINARY ☐ Genital sores or ulcers ☐ Kidney Failure/Problems ☐ Kidney stones ☐ Painful/difficult urination (Prostatitis) ☐ Testicular pain ☐ Urinary discharge ☐ None HEMATOLOGY/ONCOLOGY ☐ Easy bruising ☐ Prolonged bleeding ☐ None RESPIRATORY ☐ Wheezing ☐ Cough ☐ Coughing up blood ☐ Severe or Frequent colds ☐ Difficulty breathing ☐ None	INTEGUMENTARY ☐ Rash ☐ Change in mole ☐ Skin sores ☐ Skin cancer ☐ Sever itching ☐ Loss of hair ☐ None MUSCULOSKELETAL ☐ Muscle aches ☐ Joint pain ☐ Difficulty laying flat due to muscle pain ☐ Back pain ☐ None NEUROLOGIC ☐ Weakness ☐ Headaches ☐ Scalp tenderness ☐ Dizziness ☐ Paralysis of extremities ☐ Tremor ☐ Stroke ☐ Numbness or tingling ☐ Seizures or convulsions ☐ Fainting ☐ None HENT ☐ Hearing loss ☐ Sore throat ☐ Runny nose ☐ Dry mouth ☐ Jaw Claudication (pain in jaw when chewing) ☐ Ear ache
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NAME

DATE OF BIRTH

DATE COMPLETED



Multi-cancer early detection

Please answer Yes or No to the following questions:

1. Do you have a family history of cancer?
 - a. If yes, were they rare cancers such as ovarian, male breast, or pancreatic cancer?
2. Would you be interested in a blood test that can detect 50 types of cancers as early as stage 1?
3. Do you have a history of HPV?
 - a. If so, are you concerned about developing HPV-related Cervical or Head/Neck cancer?
4. Would you like Dr. Pho to discuss this test with you during your appointment?