HOAN PHO M.D.
INTERNAL MEDICINE • WELLNESS • AESTHETICS

# *DISCLAIMER*

Due to an increase of COVID-19 cases, Dr. Pho visits/treats COVID-19 positive patients in the hospital. To reduce your risk of infection, he highly encourages both new and current patients to get vaccinated before consulting in person.

Please note: Dr. Pho is **NO LONGER** prescribing ivermectin for prevention.

We apologize for any inconvenience.

13150 NW Military HWY Dr
San Antonio, TX 78231
Phone: (210) 541-4164
Fax: (210) 541-4168

## Please Print Clearly

Patient Name: _____ 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:

Do you have Medicare? YES NO

**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 ANS 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 herby give procedures as maybe necessary for the best care of the patient. The undersigned also does herby give authorization for Integrative Health Solutions to web-enable for personal email, thus allowing email notifications of passwords and patient portal notifications.

Patient Signature: _____ Date:_____

**PAYMENT IS DUE AT THE TIME OF SERVICE**

# Medication Information

Allergies: _____

_____

Current Medications to include Over The Counter medications and supplements:

# 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: _____

| Medication | Dose | Frequency |
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| Medication | Dose | Frequency |
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# Voice Mail Authorization

_____ I authorize _____ 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 _____ 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: _____

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# 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

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# 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.

NEW POLICY EFFECTIVE DECEMBER 2022

**Integrative Health Solutions**

**Hoan Pho MD**

13150 NW Military HWY Dr, San Antonio, TX 78231

Phone: 210-541-4164  Fax: 210-541-4168

# FINANCIAL POLICY STATEMENT

Recent changes in healthcare have made it necessary for Integrative Health Solutions to implement changes in our Financial Polices. Our main goal it 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 filling 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 your respond promptly to any inquires 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 form your insurance. As a service to you we will file your claims to the insurance your have provided. Should the information provided be invalid or expired, you will be responsible or 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.
4

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 BILLINGHISTORY 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.

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

SIGNATURE DATE

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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

**Respiratory:**

- ✈ Wheezing
- ✈ Cough
- ✈ Coughing up blood
- ✈ Severe or Frequent colds
- ✈ Difficulty breathing
- ✈ 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

**HENT:**

- ✈ Hearing loss
- ✈ Sore throat
- ✈ Runny nose
- ✈ Dry mouth
- ✈ Jaw Claudication (pain in jaw when chewing)
- ✈ Ear ache

**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

**Name:** _____ **Date of Birth:** _____ **Date Completed:** _____

Galleri®
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?