Sage Medicine

Personalized Healthcare

PATIENT REGISTRATION

Patient Last Name: First Name:		DOB:	SS#
Address: Street	City	State	Zip
Gender:	Marital Status:	Race:	Email:
Emergency Contact: Name:	Phone #:	Relationship:	
Home Ph #	Work Ph#	Cell Ph#	
Employer Name and Address:			
Preferred Pharmacy Name:	Address:	Ph#:	
Referred By:			

PERSON RESPONSIBLE FOR PAYMENT

Last Name: First Name:		DOB:	SS#
Address: Street	City	State	Zip
Relationship to Patient			
Employer Name and Address			
Home Ph #	Work Ph#	Cell Ph#	

INSURANCE PLAN INFORMATION

Primary Insurance		Secondary Insurance	
Insurance Co. Name:		Insurance Co. Name:	
Group Name:		Group Name:	
Subscriber Name:	DOB:	Subscriber Name:	DOB:
Policy (ID)#:		Policy (ID)#:	
Group #:		Group #:	
Effective Date:		Effective Date:	

Relationship to patient:	☐ Self	☐ Spouse	☐ Child	☐ Other

NO INSURANCE_____ Copy of Driver's License/Ins Cards Attached: Yes_____ No_____

ASSIGNMENT OF BENEFITS AND PATIENT'S AUTHORIZATION

I hereby authorize Sage Medicine, PA to submit claims on my behalf for services rendered. I request payment to be made directly to Sage Medicine, PA. I verify the accuracy of the above information and I authorize the release of any necessary information, including medical information, necessary to process any claims. I authorize payment directly to the physician or supplier for the services described.

PAYMENT AT THE TIME OF SERVICE IS THE PATIENT'S RESPONSIBILITY.

Signature of Patient or Responsible Party_____ Date_____

For office use only: Entered by: _____ Date:_____

4315 Moonlight Way #102
San Antonio, Texas 78230

Carmen Cawley, MD, FACP
T:210-510-2141 F:210-510-2135

Sage Medicine

4315 Moonlight Way #102
San Antonio, Texas 78230

Carmen Cawley, MD, FACP

Patient Name: _____ Today's Date: _____

SS/HIC/Patient ID # _____ Age: _____ Birthdate: _____

What is your reason for visit? _____

Symptoms

Check ☑ symptoms that you have

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue

Eye, Ear, Nose, Throat
- ☐ Vision problem or change
- ☐ Hearing problem or change

Pain or drainage from:
- ☐ Eyes
- ☐ Ears
- ☐ Nose/sinus
- ☐ Mouth/throat
- ☐ Loss of smell / taste

Neck
- ☐ Lumps
- ☐ Goiter
- ☐ Pain
- ☐ Stiffness

Breast
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge
- ☐ Swelling/enlargement

Pulmonary
- ☐ Cough
- ☐ Productive sputum
- ☐ Wheeze
- ☐ Shortness of breath
- ☐ Sleep on more than 1 pillow

Cardiac
- ☐ Chest pain at rest
- ☐ Chest pain on exertion
- ☐ Murmur
- ☐ Palpitations

Vascular
- ☐ Pain calves when walking
- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots
- ☐ Swelling of ankles

Gastrointestinal
- ☐ Heartburn/Indigestion/gas
- ☐ Pain or problem swallowing
- ☐ Stomach pain
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Fecal Incontinence
- ☐ Constipation
- ☐ Bloating/distension
- ☐ Mass
- ☐ Change in bowel habits
- ☐ Vomiting blood
- ☐ Rectal Bleeding
- ☐ Melena (tarry black stools)
- ☐ Hemorrhoids

Urinary
- ☐ Frequent urination
- ☐ Urgency
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Hesitancy with urination
- ☐ Incontinence
- ☐ Stones (kidney, bladder)
- ☐ Recurrent UTI's

Endocrine
- ☐ Thyroid problem
- ☐ High glucoses
- ☐ Low glucoses
- ☐ Increased thirst
- ☐ Increased sweats
- ☐ Heat intolerance
- ☐ Cold intolerance

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Gout
- ☐ Neck pain
- ☐ Back pain
- ☐ Change in mobility

Neuropsychiatric
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Headaches
- ☐ Depressed mood
- ☐ Sleep increased or decreased
- ☐ Interest activities decreased
- ☐ Guilt/worthless feelings
- ☐ Energy low/fatigue
- ☐ Concentration difficulty
- ☐ Appetite increased or decreased
- ☐ Increased anxiety or agitation
- ☐ Suicidal thoughts

Heme
- ☐ Anemia
- ☐ Increased Bleeding
- ☐ Increased Bruising
- ☐ Transfusions
- ☐ Familial d/o (clotting/bleeding)

Skin
- ☐ Rash
- ☐ Lumps
- ☐ Sores or ulcers
- ☐ Dryness
- ☐ Color changes
- ☐ Hair changes
- ☐ Nail changes
- ☐ Hives
- ☐ Itching

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Menopause
- ☐ Vaginal discharge
- ☐ Breast discharge

Date of last menstrual period: _____ Date of last mammogram: _____

Date of last pap smear: _____ Method of contraception _____

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Number of living children: _____ Are you pregnant? _____

Men Only
- ☐ Sexual difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Medical Conditions

Check ☑ conditions that you have or have had (please elaborate)

Condition	
☐ Alcohol dependence	☐ High blood pressure
☐ Allergies/hay fever/ Sinusitis	☐ High cholesterol
☐ Anemia (Iron, B12...)	☐ HIV/AIDS
☐ Anorexia/Bulimia	☐ Hypothyroid
☐ Angina/Chest pain/Heart attack	☐ Hyperthyroid
☐ Arthritis	☐ Incontinence (Urge, Stress...)
☐ Asthma / Emphysema	☐ Irregular or fast heart beat
☐ Autoimmune disease (Lupus, Sjogren's, Scleroderma…)	☐ Irritable Bowel Syndrome
☐ Bleeding / Clotting disorder	☐ Mitral Valve Prolapse
☐ Cancer Type:	☐ Memory problem/Dementia
☐ Celiac Disease	☐ Mononucleosis
☐ Chronic bronchitis/Emphysema	☐ Neuromuscular disorder
☐ Chronic kidney disease	☐ Obesity
☐ Chronic liver disease	☐ Pacemaker
☐ Colon disorder (Ulcerative colitis, Crohn's, Diverticulosis, IBS…)	☐ Polio
☐ Congestive Heart Failure or enlarged heart	☐ Prostrate problem
☐ Chicken Pox/Shingles	☐ Psychiatric (Anxiety, Bipolar, Depression, Anxiety, ADD…)
☐ Diabetes I or II	☐ Rheumatic Fever
☐ Drug dependency	☐ Seizures/Epilepsy
☐ Fibromyalgia	☐ Sleep Apnea
☐ Genetic Disorder	☐ Stomach ulcers / Duodenal Ulcers
☐ Goiter/thyroid nodules	☐ Stroke or mini-stroke
☐ Gout	☐ Suicide Attempt
☐ Headaches (Migraine, Tension..)	☐ Sexually Transmitted Disease
☐ Head injury	☐ Sickle Cell anemia
☐ Heart - Abnormal Beat (slow, fast, irregular...)	☐ Skin Disorders (Acne, Psoriasis...)
☐ Heartburn	☐ Tuberculosis
☐ Hemorrhoids/rectal problems	☐ Urinary Tract Infections (only if recurrent)
☐ Hepatitis (A,B,C, Non Infectious)	☐ Valve disease / heart murmur
☐ Hernia Abdominal	☐ Vascular disease (carotid, heart, renal, peripheral arteries)
☐ Hernia Inguinal	☐ Vein problems / cellulitis / leg ulcers / vericose
☐ Other	☐ Other

Medications List medications, supplements, and herbs you are currently taking

Medication	*Dosage*	*Frequency*	*Medication*	*Dosage*	*Frequency*

Allergies to medications and foods (describe reaction like rash, anaphylactic shock…)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Partnered

Are you sexually active? ☐ Yes ☐ No

Have you ever been physically or verbally abused by a partner? ☐ Yes ☐ No

Health Habits Check ☑ substances you use **and describe how much you use**

☐ Tobacco

☐ Alcohol

☐ Drugs

☐ Caffeine

Occupational Check ☑ if your work exposes you to the following:

☐ Stress ☐ Hazardous Substances

☐ Heavy Lifting ☐ Other

Occupation:

Family History - list Arthritis, Gout, Asthma, Allergies, Cancer, Chemical Dependency, Diabetes, Heart Disease, Strokes, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Tuberculosis, Mental Disorder

Relation	Age	Cause of Death	Age at Death	Diseases?
Father				
Mother				
Brothers				
Sisters				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Surgeries

Date	Hospital	Surgery or Illness

Serious Illnesses/Hospitalizations

Vaccines

	Date of last vaccine
PneumoVax 23 (1 or 2)	
Tetanus—Td every 10 yrs	
Tetanus—TdaP (1)	
Hepatitis B series (3)	
Hepatitis A series (2)	
MMR (1 before & after 50)	
HPV (gardasil or cervarix—3)	
Meningococcal (1)	
Zostavax (1 over 50)	
Varicella (2 if no chickenpox)	
Colonoscopy (screening) Result	
Prevnar	
Shingrix	
Other	

**** Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No** If yes, give approximate date: _____

Pregnancy Complications

Year	Complication

DO YOU HAVE ADVANCED DIRECTIVES? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ *Date:* _____

Reviewed By: _____ Date: _____

SAGE MEDICINE
PERSONALIZED HEALTHCARE

FINANCIAL AND OFFICE POLICIES

Thank you for choosing Sage Medicine, PA as your healthcare provider. We are committed to providing our patients with the best available medical care. The following covers our financial and office policies.

_____1. All co-pays, deductibles, and/or co-insurances are due at the time of service. We do not choose these fees. They are provided to our office by your insurance company when we verify your benefits and/or the terms agreed upon by you (or your employer) and the insurance company.

_____2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit by your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have questions regarding your health care coverage. Sage Medicine, PA provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.

Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract.

_____3. We will collect all co-payments, deductibles or charges for non-covered services currently due upon check in. If you have a balance on your account we will ask for that payment as well. For your convenience, we accept cash, check, Visa and Mastercard.

_____4. We allow 60 days for payment of any balances that are the responsibility of a patient. If we do not receive payment in full and/or if we are not contacted to make payment arrangements within 60 days, the account will be referred to our billing department, who will contact you regarding a payment plan. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

4315 MOONLIGHT WAY #102
SAN ANTONIO, TEXAS 78230

CARMEN CAWLEY, MD, FACP
T:210-510-2141 F:210-510-2135

_____ 5. Please ensure that all personal and insurance information is correct at the time of each visit. We will only bill the insurance company on file. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communication. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future).

_____ 6. If you are more than 15 minutes late for your appointment, we will reschedule your appointment.

_____ 7. If your personal check is returned for insufficient funds, closed account, etc., there is a $35.00 charge in addition to the amount of the check. After one instance of a returned check, all further payments will be required to be in the form of credit card, cash or money order only.

For patients without insurance

_____8. Our fees cannot always be determined in advance, since they depend on services rendered. Payment in full is due at the time of service in order to receive cash pay discounts for self-pay.

Signature of Responsible Party:_____ Date: _____

Patient's name printed:_____

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SAGE MEDICINE
PERSONALIZED HEALTHCARE

FORM FEES AND COPIES OF MEDICAL RECORDS

Due to the volume of form requests and copies of medical records, we have been forced to charge for their completion. An example of charges is listed below. These fees must be paid in full when the form is picked up or prior to its mailing.

FORMS	FEES
Short forms, i.e. Department of Motor Vehicles	$15.00
Special letters per patient request (grievance, appeals, or letters of medical necessity)	$25.00
Family Medical Leave (FMLA) Forms	$25.00
Copying / Faxing of medical records for your own use	$25.00 for first 50 pages, $5.00 for each additional 50 pages + cost of mailing. (as a courtesy Sage will send records to internal referrals)
Disability Letters (can take 2-4 weeks)	$50.00

Please allow 3-5 business days for these requests to be completed.

Thank you for understanding our financial and office policies. Please let us know if you have any questions or concerns.

I have read and understand the above information.

Signature of Responsible Party: _____ Date:_____

Patient's name printed: _____

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SAGE MEDICINE
PERSONALIZED HEALTHCARE

MEDICAL RECORDS RELEASE FORM

This form is for use when such authorization is required and complies with the
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Patient name: _____ DOB: _____

Patient address: _____

City/State/Zip: _____ Phone:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the entity listed below.

I hereby authorize the release of information:

From:

_____
_____
_____
_____
_____
_____

TO:

Carmen Cawley, MD
Sage Medicine, PA
4315 Moonlight Way
Suite 102
San Antonio, TX 78230
Phone: (210) 510-2141
Fax: (210) 510-2135

Information to be released:

☐ All items indicated below:

☐ Progress Notes / Consultation Notes (1 year only)
☐ Medical Summary
☐ Pathology Reports
☐ Immunization Records
☐ Endoscopy Reports
☐ Lab Reports
☐ Radiology Reports
☐ Cardiac Reports
☐ Pulmonary Reports
☐ Operative Reports
☐ ER Records: Date:_____
☐ Hospital Records: Date:_____
☐ Other: _____

Please respond to this request within a reasonable time to avoid delays in patient care.

_____ _____
Patient, guardian, or legal representative (signature) **Date:**

Office use only:
Date faxed: _____ Date mailed: _____ Initials: _____

SAGE MEDICINE
PERSONALIZED HEALTHCARE

MEDICAL RECORDS RELEASE FORM

This form is for use when such authorization is required and complies with the
Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards

Patient name: _____ DOB: _____

Patient address: _____

City/State/Zip: _____ Phone:_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the entity listed below.

For the period of 9-1-2019 to Current

I hereby authorize the release of information:

From:

UT Health Medical Arts & Research Center
Family Medicine / Primary Care
MARC – Mail Code 8303
8300 Floyd Curl Drive, 1st Floor
San Antonio, TX 78229
Phone: (210) 450-9760
Fax: (210) 450-6058

TO:

Carmen Cawley, MD
Sage Medicine, PA
4315 Moonlight Way
Suite 102
San Antonio, TX 78230
Phone: (210) 510-2141
Fax: (210) 510-2135

Information to be released:

☑ All items indicated below:

☐ Progress Notes / Consultation Notes (1 year only)
☐ Medical Summary
☐ Pathology Reports
☐ Immunization Records
☐ Endoscopy Reports
☐ Lab Reports
☐ Radiology Reports
☐ Cardiac Reports
☐ Pulmonary Reports
☐ Operative Reports
☐ ER Records: Date:_____
☐ Hospital Records: Date:_____
☐ Other: _____

Please respond to this request within a reasonable time to avoid delays in patient care.

_____ _____
Patient, guardian, or legal representative (signature) **Date:**

Office use only:
Date faxed: _____ Date mailed: _____ Initials: _____

SAGE MEDICINE
PERSONALIZED HEALTHCARE

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations • The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

The federal privacy laws limit our ability to communicate with your family and others who participate in your medical care. Please **list those individuals with whom you would allow us to share your health information,** if necessary.

_____ _____
Person who may receive medical information Relationship

_____ _____
Person who may receive medical information Relationship

_____ _____
Patient Name (please print) Date

_____
Patient signature

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SAGE MEDICINE
PERSONALIZED HEALTHCARE

PRESCRIPTION MONITORING

1. Mandatory Texas Prescription Monitoring Database or PMP Database checking starting March 1,2020:

All Texas Physicians are required to check the PMP Database before prescribing or continuing to prescribe opioids like norco, benzodiazepines like xanax, stimulants like adderall, barbituates, or carisoprodol or soma. This is a state program to help prevent drug abuse, doctor shopping and/or drug diversion. We will expect our patients to follow certain guidelines like calling for refills Monday through Friday and keeping appointments as stated in our controlled substance policy (you will be asked to sign if using these medicines chronically).

2. Voluntary pharmacy connection through electronic medical record to help gather data on prescriptions and help your safety:

Sage Medicine has the ability to download your medication history through a secure internet network. This will allow our providers to prescribe medication without duplicating medications prescribed by other physicians and prevent medication allergies, errors and serious drug interactions. By signing below, I give my permission to Sage Medicine to download this information.

Patient Name: _____
Please Print

_____ _____
Patient Signature Date

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SAGE MEDICINE
PERSONALIZED HEALTHCARE

DISMISSAL POLICY

1. Appointments not canceled with a 24 hour notice and any "no show" appointments will be subject to a charge of $50.00. Please note that this fee is not covered by your insurance company. We will waive this fee once if there was an unexpected emergency. If unable to keep an appointment, please reschedule more than 24 hours in advance, if possible. When an appointment is rescheduled several days ahead of time, this allows other patients the opportunity to be seen.

   _____
   Patient initials

2. After 3 "no show" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to you. Other causes for termination at the discretion of the physician include noncompliance with treatment plan, failure to comply with controlled substance rules, failure to comply with refill policy and/or disrespect of the office staff or provider/

   _____
   Patient initials

3. Patients may be discharged from physician care if not seen in the past 18 months. This indicates to our office that you have not had any type of follow up, lab work or medication refills. We would assume that you have found a new PCP or are receiving treatment from a specialist. We will notify you in writing that your account is no longer active and we are terminating the physician/patient relationship.

   _____
   Patient initials

Print Name_____

Signature_____ Date_____

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