Dorothy Cohen Serna, M.D., P.A.
Kelly M. Englund, M.D.
Internal Medicine
www.northcypressinternalmedicine.com

21216 Northwest Fwy, #460
Cypress, TX 77429
Phone 281-807-5300
Fax 281-807-5311

REGISTRATION INFORMATION

(PLEASE PRINT)

Date_____ **Home Phone** _____

Cell Phone _____

Patient _____

Last Name First Name Initial

Street Address _____

City _____ State _____ Zip_____

Sex □M □F **Age**___ **Birth date**_____ **Social Security #(Patient's)**_____

□Single □Married □Widowed □Separated □Divorced

Please note that we have been mandated to collect data on the following three questions:

Preferred Language English Other _____

Race oCaucasian oAfrican American oAsian oNative American oOther oDecline to Answer

Ethnicity oNon-Hispanic oHispanic oOther oDecline to Answer

Employed by Business Name _____ □Full-Time Student □Part-Time Student

Business Address _____

Occupation _____ Business phone _____

Spouse (or responsible party) Name _____ Birth date _____

Employer _____ Occupation _____

Cell Phone Spouse (or responsible party) _____ Business phone _____

Who is responsible for this account? _____Relationship to Patient _____

Do you have Medical Insurance? □Yes □No

Name of Primary Insurer _____

ID# _____ Group # _____

Who is the insured? □Self □Spouse □Parent **Insured's Soc.Security#** _____

Name of Secondary Insurer (if any) _____

ID# _____ Group # _____

Are you covered under any of these programs? Medicare Medicaid ChampVA Worker's Comp

Is your condition related to employment (current or previous)? □No □Yes

Is your condition related to auto accident? □No □Yes Other Accident ? □No □Yes

In case of emergency, who should be notified?_____
Phone Relationship to patient

Form revised 3/19/12

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(OVER)

Please list other doctors you have seen in the past 5 years:

1. _____ City/State _____
(General Practitioner, Specialist, or other)

2. _____ City/State _____
(General Practitioner, Specialist, or other)

Reason for seeing _____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

ASSIGMENT AND RELEASE

I, the undersigned have insurance coverage with _____
Name of insurance Company

And assign directly to **DOROTHY COHEN SERNA, M.D., P.A.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. If my insurance changes in the future, with my signature here I am as well agreeing to all provisions herein to apply to my new insurance carrier.

I also acknowledge that insurance is only a method of payment and that my policy may contain certain limited and/or restricted guidelines for payments on various procedures which constitute 'their' reasonable and customary limits.

I agree to pay DOROTHY COHEN SERNA, MD, PA for any charges denied and/or remaining balance for professional services provided beyond the sums paid by my insurance carrier(s).

I understand that North Cypress Medical Center is a Physician Owned and Operated Hospital and that Dr. Serna has an ownership interest in the hospital.

I understand that if North Cypress Medical Center is out of network with my Insurance Plan, I will be eligible for a significant prompt pay discount by paying on a timely basis. I understand that if I have questions or concerns about this, I can confer with my Doctor or the North Cypress Medical Center Business Office prior to any services being rendered at that facility.

I also understand that my Doctor is an Attending Physician at hospitals that may be out of network with my Insurance Plan. I understand that I have the option to get my care at either an in-network or an out-of-network facility and that if I have any questions regarding this, I can ask my Doctor or the Business Office for more information.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **DOROTHY COHEN SERNA, M.D., P.A.** for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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