Mark F. Kneuper, MD 652 N. Houston Ave., Ste. 3 New Braunfels, TX 78130 (830) 625-6258

Patient Information:

	Today's Date:		
Name:			
First	Middle		Last
Mailing Address:		City/St/Zip:	
Home Phone:	Cell:	Work:	
Email:	Marital Status:		
Social Security:			
Occupation:		_Employer:	
Address:		Phone #:	
Primary Physician:		_Phone #:	
Emergency Contacts:			
1. Name:			
2. Name:			
Pharmacy:		Location:	
Medication Allergies:			_Reaction:
Race: African American Native Hawaiian		_	○ White (includes Hispanic)
Ethnicity: O Hispanic O Non-His	spanic O Decline		
Do you have insurance coverage?	○YES ○N	0	
Primary Coverage:		Policy #:	
Secondary Coverage:		Policy #	

Have you had any recent im	aging, lab work, etc. pertaining to today's visit? () YES () NO
If so, where and when?	
How did you hear about us	?
○ TV Commercial	○ Yellow Pages
Radio	◯ Search Engine (Yahoo, Google, etc.)
	O Doctor's Referral Who?
○ Website	Friend/Family Referral Whom may we thank for your referral?
_	ipt of Notice of Privacy Policies: Policies in the waiting room, copies are available upon request)
•	W BRAUNFELS SURGICAL ASSOCIATES Notice of Privacy Policies
Signature of Patient/Paren	t/Guardian Date
Patient Authorization:	
I authorize Mark Kneuper, N	M.D. to submit insurance claims using my signature on file below.
I authorize the release of ar claim.	ny medical information necessary in order to process this assignment on the
I authorize payment of med on the claim form.	lical benefits to be paid directly to Mark Kneuper, M.D. for services described
Signature of Patient/Paren	t/Guardian Date

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NEW PATIENT QUESTIONNAIRE

Name:	Date:DOB:	
What is the reason for your visit today		
What do you think this complaint is du	e to?	
	Duration:	
MEDICATION ALLERGY:REACTION:		
SOCIAL HISTORY		
Do you: Smoke? Y / N How much? Drink Alcohol? Y / N How Much?	Quit Date:	
Drink rear Y / N How much?		
Drink Coffee? Y / N How Much?		
Comments:		
· · · · · · · · · · · · · · · · · · ·		
List Surgeries with Dates:		
	Date:	
	Data:	
	Data	
Other Medical Conditions:		
· · · · · · · · · · · · · · · · · · ·		
Health Status or cause of death/ Father	er/Age	
Health Status or cause of death/ Moth	ier/Age	
Any diseases/bleeding disorders in yo	our family	
Has any family member had complica	tions from anesthesia?	

Home Medication List

Prescriptions or Over the Counter medications
Please fill out in its entirety.

Name:	Date:			
Medication	Dosage (mg/mcg/ml)	How often?	By mouth or injection?	Medical reason
				-
			·	
	·			
ALLERGIES:			Reaction:	
o <u>I do not ta</u>	ake any regular preso	cription medic	cations.	
Patient Signature) :			

<u>Mark F. Kneuper, M.D.</u> 652 N. Houston St. Ste 3 New Braunfels, TX 78130

BILLING AND FINANCIAL POLICIES

Payment for services rendered is payable at the time of services. Your insurance company may notify you if a charge is applied to your deductible or denied for some reason. It is your responsibility to notify us when you receive this kind of information and to make an arrangement to pay your financial obligation. We strongly recommend that you contact your insurance company(ies) if you have a problem with a payment or denial for services provided to you.

Co-pays are due before you see the doctor. If you do not have your co-pay for your visit we will re-schedule you. Please note that not all services provided in the office are covered under your co-pay. Services such as office surgeries, injections, and other in office procedures are usually subject to your deductible and co-insurance. If you cannot make your appointment, please call to reschedule. There will be a \$35 charge for all no show appointments. All co-pays and deductible amounts deemed your responsibility are due at the time of service.

A quotation of benefits is not a guarantee of payment by your insurance company. Any amounts not paid by your insurance company, regardless of what benefits were quoted, will be due from you. If you have any questions regarding our billing or your charges, please do not hesitate to ask us about them.

Your account is considered <u>past due, 30 days</u> following billing unless other arrangements have been made. Patients with an outstanding balance over <u>60 days</u> will be charged simple interest of 5%. Should you have financial problems that result in delaying payment of your bill, please contact us so that we can set up a payment arrangement. There is a \$50 insufficient funds fee for all returned checks and if this does occur, all financial arrangements made will be null and void and the entire balance of the account will be due immediately. If your account is placed with a collection agency there may be a fee of \$35 charged to your account and you will be responsible for any additional collection fees assessed by the collection agency.

SURGERIES

Surgeries (including office surgeries) are usually subject to your deductible and coinsurance. All patient deductibles and/or co-insurance amounts must be paid in full prior to the date of surgery. An estimate of patient responsibility will be prepared for you. Please contact the billing office with any questions regarding this estimate. This estimate is based on the benefit levels and coverage of your insurance plan.

PAYMENT

For your convenience, we accept cash, checks, MasterCard, Visa, American Express and Discover cards. CareCredit is also available to our patients. Please ask our staff for more information regarding payment options.

WE DO NOT FILE WORKERS' COMPENSATION CLAIMS. NO EXCEPTIONS!

Signature:	Date:	
Signature	Datc	