Patient Information / Información del Paciente

Patient
Paciente: ______________________ ______________________ ______________________ Male OR Female
(First Name/ Primer Nombre) Middle Name / Segundo Nombre (Last Name/ Apellido) Hombre o Mujer

Address
Dirección: ______________________ City
Ciudad: ______________ State
Estado: ________ Zip
Código: __________

Home Phone
Teléfono: ______________________ Other Contact Number
Otro Numero de Contacto: ______________________

Date of Birth
Fecha de Nacimiento: ______________________ Social Security Number
Numero de Seguro: ______________________

Check One
Cheque Uno: ______ Single/ Soltero ______Married/ Casado(a) ______ Widowed/ Viudo(a) ______ Seperated/ Separado(a) ______Divorced/ Divorciado(a)

Employer
Empleador: ______________________ Business Phone
Teléfono del Trabajo: ______________________

This section must be completed / Esta parte debería de estar completa:

Guarantor of Account:
Persona responsable del pago: ______________________ ______________________ ______________________
(First Name/ Primer Nombre) (Middle Name/ Segundo Nombre) (Last Name/ Apellido)

Address
Dirección: ______________________ City
Ciudad: ______________ State
Estado: ________ Zip
Código: __________

Relation to Patient
Relación al Paciente: ______________________

Home Phone
Teléfono: ______________________ Other Contact Number
Otro Numero de Seguro: ______________________

Date of Birth
Fecha de Nacimiento: ______________________ Social Security Number
Numero de Seguro: ______________________

In case of emergency, who should be notified? ______________________ Home Phone: ______________

En caso de una emergencia a quien podemos contactar? ______________________ Teléfono ______________

Method of Payment / Método de pago:

_______ Cash/ Efectivo _______ Check/ Cheque _______ Credit Card/ Tarjeta De Crédito _______ Insurance/ Aseguranza

_______ Medicaid _______ Medicare _______ Workers' Compensation/ Compensación del Trabajo

The undersigned hereby authorizes the release of information relating to all claims for benefits submitted on behalf of myself and/ or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for any services to be rendered, without obtain my signature on each and every claim to be submitted for myself and/ or dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim. I irrevocably assign and transfer all benefits of my insurance company otherwise payable to me, to Texas Medical Clinic for services as described on the attached forms. I understand I am financially responsible for all charges incurred, and at the end of 90 days, any claims will billed directly to me. I further acknowledge that any insurance benefits, when received by and paid to Texas Medical Clinic, will be credited to my account or my dependent's account.

Con mi firma yo autorizo dar mi información de los derechos y benéficos a someter de mi y mis dependientes. Además yo concuerdo y reconozco que mi firma en este papel autoriza que mi doctor puede someter los beneficios, para servicios hechos, sin mi firma cada derecho para someter de mí y mis dependientes, y limitado con esta firma. Yo asigno y transferencia los beneficios de mi aseguranza do otros modos pagaderos a mí, La Clínica para servicios en las formas juntados, Yo comprendo que yo soy responsable de los cobros clínica, estarán créditos a mi cuenta o de mis dependientes.

X Signature/ Firma: ______________________ **Date/ Fecha**: ______________

Patient Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I, ________________________, understand that as part of my health care, Texas Medical Clinic originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for further care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Texas Medical Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. But I do not have to sign this authorization in order to receive treatment at Texas Medical Clinic.

I further understand that Texas Medical Clinic reserves the right to revise their notice of privacy practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Texas Medical Clinic change their notice, they will post a current copy of any revised notice in their office in a visible location at all times, and I may request a copy at any time.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another healthcare entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

X ________________________________ ________________________

Patient Signature Date

Please answer the following questions/ Por favor conteste las siguientes preguntas:

Race/Raza:

- o White
- o African American
- o Hispanic
- o Other Race_________________

Ethnicity/Origen Etnico:

- o Hispanic or Latino
- o Non Hispanic or Latino

Language/Idioma:

- o English
- o Indian(Includes Hindi)
- o Spanish
- o Other___________________

Preferred Pharmacy & Location/ Farmacia Preferida y Ubicación:

____

E-mail/Correo Electronico:____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Texas Medical Clinic's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal information:

____

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

X Signed: _________________________ Date: _________________________

If not signed by patient, please indicate relationship to patient (ex. Spouse, parent)

Relationship: _____________________ Witnessed by: __________________

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____________________

By (name and title): _____________________________

Texas Avenue Medical Clinic
Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

1. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advanced by our staff. We accept cash, checks, MasterCard, Visa, America Express, and Discover.

2. Keep in mind that your insurance policy is basically a contract between you, your employer, and your insurance company. We are not a party to that contract. As a service to you, we will file your insurance claim if you assign the benefits to Texas Medical Clinic-in other words; if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. Not all insurance plans cover all services. Any information received from the insurance company prior to your visit is only an explanation of benefits and not a guarantee of payment. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

6. In the event your check is returned unpaid, a $25.00 service fee will be applied to your account.

7. All balances exceeding 90 days past due will be sent to our collection agency, unless prior financial arrangements have been made with and approved by the Texas Medical Clinic billing department.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I have read and understand Texas Medical Clinic's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party, if minor) Date

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Please print the name of the patient