# Patient Registration Form

Patient's Name: _____ Gender: ☐ Female ☐ Male

Date of Birth: ___ / ___ / _____ Social Security (SS) # _____ - ____ - _____

Driver's Licence #: _____ Cellphone Number : (____) _____ - _____

Primary E-Mail: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Primary Address: _____
(Street / Lot Number)

_____
(City) (State) (Zip Code)

Ocupation: _____ Employer: _____

Business Phone: (____) _____ - _____

Employer Address: _____

Name of Responsible party if different from patient: _____

Phone Number: (____) _____ - _____ Relationship to Patient: _____

Address: _____
(Street / Lot Number)

_____
(City) (State) (Zip Code)

¿Is the patient a minor? ☐ Yes ☐ No

If minor, Mother's Name: _____ SS# _____-____-_____ Date of Birth: ___/___/_____

Father's Name: _____ SS# _____-____-_____ Date of Birth: ___/___/_____

Spouse's Name: _____ Ocupation: _____

Phone Number: (____) _____ - _____ Employer Address: _____

**Person to contact in case of Emergency (other than spouse):** _____

**Relationship to patient:** _____ **Phone Number**: (____) _____ - _____

**Business Phone**: (____) _____ - _____

Refered by: _____ Name of Previous Provider: _____

Primary Insurance: _____ ID #_____

Policy Holder: _____Group #_____ Ph #(____) _____ - _____

Secundary Insurance: _____ ID #_____

Policy Holder: _____Group #_____ Ph #(____) _____ - _____

- **I authorize the release of any medical or other information necessary to process claims on my behalf to DONNA MEDICAL CLINIC, PA. I understand that I am financially responsible for all charges whether or not paid by insurance. A Photocopy of this release is to be considered as valid as the original.**

Date Signature

(Name and Signature of witness of patient can't sign)

## Financial Policy & Agreement

Welcome to the Donna Medical Clinic, PA. In order for our medical staff to be able to deliver the quality of care that you are accustomed to, we have established our financial policies. The following is a list of guidelines that are necessary in order to provide high quality care and make your visit as pleasant as possible.

**PLEASE READ ALL INFORMATION AND ACKNOWLEGE BY SIGNING BELOW**

1. **We ask that you present your insurance card at each visit. It is your responsibility to provide us with the correct information to bill your insurance claims.**
2. **If you have a change of address, telephone numbers, or employer, please notify the receptionist upon signing in.**
3. **We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, visa, MasterCard and discover.**
4. **If we do not participate with your insurance company, you will be expected to make payment in full at the time services are rendered.**
5. **If your insurance denies our charges or does not pay us in a timely manner, or if your account becomes delinquent we reserve the right to refer your account to a collection agency and to be reported to one or more credit bureau(s).**
6. **MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) will be collected at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare Deductible is met.**
7. **HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. Your co-payment will be collected at the time of service-no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has the physician and / or nurse practitioner you are seeing in our office as your PCP. If you plan requires you to have an authorization to see a specialist, you will need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will verify your out of network benefits, file your charges, and will expect payment of your portion of the charges at the time of service. If we are not your primary care physician, we will not be able to obtain an authorization for you to see a specialist or admit you to the hospital.**
8. **SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full; you must contact our billing department prior to seeing the physician and or Mid-Level provider to payment arrangements.**

9. **NO SHOW OR MISSED APPOINTMENTS: When an appointment is scheduled with the physician or midlevel provider, time is specifically allocated for you. When an appointment is not canceled in advance, and the patient "no shows", another patient needing to be seen could have used that slot. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. If three appointments are missed, you will be dismissed from the practice for noncompliance.**
10. **Your insurance is a contract between you, your employer and the insurance company. We are not a part of that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policy holder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.**
11. **Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing office at 956-464-2402.**

**I / We hereby agree to the following:**

i. **GUARANTY OF PAYMENT: Medical care has been or will be provided to the patient whose name appears below. I / We, both jointly and individually, shall be fully responsible for payment for the patient's physician bill, based upon the physicians posted charges, which I/We agree are fair and reasonable. The physician my demand full payment of the patients bill at any time, but the physician is not required to do this. Even if the physician doesn't demand immediate payment, my / our obligation to make such payment remains the same.**

ii. **When the patient's insurance coverage is insufficient. If any insurance coverage which the patient may have, such as but not limited to (BCBS, AETNA, MEDICAID, HUMANA, CIGNA, WORKERS COMPENSATION) or any other coverage rejects the patients claim, or allows only part of the claim, I/We shall be responsible for immediate payment of the balance due, as determined by the physician.**

**I have read and have a full understanding of the financial policy of Donna Medical Clinic, Donna Day & Night Clinic, Elsa Medical Clinic and Arango & Peña Family Clinic.**

_____ _____

**Print Name** **Date of Birth**

_____ _____

**Signature** **Todays Date**

## Consent for service by a Physician Assistant & Family Nurse Practitioner

**Name of Patient**: _____ **DOB**:_____

**This is to certify that I have been made aware of the role and services offered by the Physician Assistant and the Clinical Nurse Specialist. I consent to be treated by the Physician Assistant and Clinical Nurse Specialist.**

_____ Date: _____

( Patient Signature)

# Notice of Privacy Practices

**YOUR INFORMATION YOUR RIGHTS OUR RESPONSIBILITIES**

DONNA MEDICAL CLINIC, PA

## YOUR RIGHTS When it comes to your health information, you have certain rights.

*This section explains your rights and some of our responsibilities to help you.*

**Get an electronic or paper copy of your medical record**
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 14 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**Ask us to limit what we use or share**
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, whom we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights have been violated**
- You can complain if you feel we have violated your rights by contacting us using the information at the bottom of this notice.
- We will not retaliate against you for file a complaint.

## YOUR CHOICES For certain health information, you can tell us your choices about what we share.

*If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.*

**In these cases, you have both the right and choice to tell us to:**
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

**In these cases, we never share your information unless you give us written permission:**
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

## OUR USES AND DISCLOSURES

**How do we typically use or share your health information?**
*We typically use or share your health information in the following ways.*

**Treat you**
- We can use your health information and share it with other professionals who are treating you.
  **Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**
- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
  **Example:** We use health information about you to manage your treatment and services.

**Bill for your services**
- We can use and share your health information to bill and get payment from health plans or other entities.
  **Example:** We give information about you to your health insurance plan so it will pay for your services.

**How else can we use or share your health information?**
*We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.*

**Help with public health and safety issues**
- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**
- We can use or share your information for health research.

**Comply with the law**
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with the federal privacy law.

**Respond to organ and tissue donation requests**
- We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**
- We can share health information with a coroner, medical examiner, or funeral director when an individual die.

**Address workers' compensation, law enforcement, and other government requests**
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement office
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.
- We do not create or manage a hospital directory.
- In addition to the federal rules regarding health care privacy, we will follow New York State law. For example, we will obtain appropriate written consent from you before we share information concerning genetic information, HIV status, substance abuse treatment, and certain mental health information for purposes other than treating you or obtaining payment for services we provide to you.

**Please ask your physician for information about how to sign up for our patient portal.**

## OUR RESPONSIBILITY

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

## CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website at **www.donnamedical.com**

COMPLAINTS: You may address your complaints to the Privacy Director of this office and to the Secretary of Health and Human Services if you believe your rights have been violated. If you feel your privacy rights have been violated, please send your complaints to: **ATTENTION ADMINISTRATION**
**P.O.BOX 2377**
**McAllen, Texas 78504**

**This Notice covers:**
- The professionals practicing at:

**Donna Medical Clinic**
**307 N. D. Salinas Blvd**
**Donna Texas 78537**

**Donna Day & Night**
**2010 U.S. 83 Business,**
**Donna, TX 78537**

**Elsa Medical Clinic**
**101 S. Broadway**
**Elsa, TX 78543**

**Arango & Peña Family Clinic**
**4903 N. McColl**
**McAllen, Texas 78504**

# Acknowledgment of Privacy Practice

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

(Patient Name) (Date of Birth)

_____ _____

(Signature of Patient or Person Representative) (Date)

*We attempted to obtain written acknowledgement receipt of our Privacy Practices, but acknowledgement could not obtained because of the following:*

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement.
- _____ Emergency situation prevented us from obtaining acknowledgement.
- _____ Other ( please specify) _____
  _____
  _____

_____ _____

Signature Date

# AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow **Donna Medical Clinic, PA.** to release any other information to these family members.

You have the right to revoke this consent in writing.

I authorize/allow Donna Medical Clinic, PA. to release my medical and/or billing information to the following individual(s):

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____

Patient Name: _____

Patient Signature: _____ Date: _____

## AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS /ANSWERING MACHINE:

Occasionally, it is necessary for the staff of Donna Medical Clinic, PA. to leave messages for patients. The purposes of these messages are to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or Schedule test results, or to ask a patient to call regarding any issue or concern. At no time will a representative of Donna Medical Clinic, PA. discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing:

Patient Name: _____+_____

Patient Signature: _____ Date: _____

For Office Use Only: Patient Number _____

To/ Para: _____ _____

(Patient Name / Nombre del Paciente) (Date / Fecha)

I, / Yo, _____, M.D. or my / M.D. o mi_____ ,

(Physician name / Nombre del Doctor) (Relationship / Relacion)

_____ , own(s) an ownership or investment interest in Doctors Hospital at Renaissance, Ltd /

(Family member name / Nombre del familiar) Soy/es accionista y Co-propietario en el Hospital de Doctors Hospital at Renaissance, Ltd.

**Receipt acknowledged / Enterado:** _____ **OR** _____

(Patient Signature / Firma del Paciente) (Guardian's Signature / Tutor Responsable)

I am referring you to Doctors Hospital at Renaissance for treatment or testing. If you object to the referral or have any questions about this notice or my interest in Doctors Hospital at Renaissance, Ltd., please let me know.

Further, your treating physician(s) at Doctors Hospital at Renaissance may have an ownership or investment interest in Doctors Hospital at Renaissance, Ltd. Therefore, to help you make a meaningful decision regarding your receipt of care, I have attached a list identifying all other physician owners or investors in Doctors Hospital at Renaissance, Ltd. If you have any questions regarding the treating physician's ownership interest, please ask the treating physician(s) or you may call DHR Administration at (956) 362-7360.
This notice is given to you as required by federal law and the hospital's rules and regulations.

Por la presente, estoy refiriendolo al Hospital de Doctors Hospital at Renaissance para tratamiento medico ó examenes. Si usted no esta de acuerdo con este referimiento ó tiene alguna pregunta sobre mi interes en Doctors Hospital at Renaissance, Ltd., favor de hacermelo saber.

El doctor con el cual se esta tratando podria ser accionista y Co-propietario. Por lo tanto, para asistirle en tomar una decision en el cuidado de su salud, adjunto se encuentra una lista donde puede identificar todos los medicos accionistas y Co-propietarios de el Hospital. Si tiene alguna pregunta, favor de comunicarse con su doctor ó puede llamar a el departamento de Administración en DHR al (956) 362-7360.
Esta información es proporcionada de acuerdo con los requerimientos por ley federal y los reglamentos de/y regulaciones del hospital.

| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |
|---|---|---|
| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |
| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |
| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |
| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |
| Date/Fecha | Procedure/ Procedimiento | Patient Signature/Firma del Paciente |