NEW PATIENT REGISTRATION FORM

Name:____ Referred By:____________________

LAST FIRST MIDDLE

Date of Birth:__________ Social Security #:________________ Driver's License #/State:________________

Gender: ☐ Male ☐ Female Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Race: ☐ African-American ☐ American-Indian ☐ Asian ☐ Asian-Indian ☐ Black ☐ Native Hawaiian

☐ White ☐ Other: ______________________________________ ☐ Decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino/Spanish ☐ Latin American/Latino ☐ Decline

Home Address:__________________________________ City:__________ State:_____ Zip Code:________

Cell #:_______________ Home #:_____________ **Email:** ____________________________________

Responsible Party / Guarantor Information

☐ Check here if same as above

Guarantor Name:____________________ Address:____

Patient's Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other________________________________

Insurance Information

Primary Insurance:__________________________________ ID Certification #:____________________

Insurance Address:____

Subscriber's Name:____________________________________ Birthdate:____________________

Policy/Group #:__________________________________ Co-Pay: $____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other______________________________

Secondary Insurance:________________________________ ID Certification #:____________________

Insurance Address:____

Subscriber's Name:____________________________________ Birthdate:____________________

Policy/Group #:__________________________________ Co-Pay: $____________

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other______________________________

Emergency Contact

Name:____________________________________ Relationship to Patient________________________

Cell #: ____________________________ Home #: ____

Pharmacy Information

Pharmacy:____________________________________ Phone: ______________________________

Location/Address:____

PATIENT CONSENT TO TREAT

I hereby give my consent to Mariela Bernal Irizarry M.D. Laredo Physicians Group and authorize him to provide my medical treatment. I understand that Laredo Physicians Group will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Laredo Physicians Group to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

Patient Name ____________________________________

Patient Signature ___________________________________ Date ______________

Parent or Legal Guardian Signature (for minor) __________________________________

Relationship to the Patient __________________________

CONSENT FOR E-PRESCRIBING & MEDICATION HISTORY

I understand that as part of my electronic health record, Laredo Physicians Group will transmit my prescriptions electronically as permitted, to the pharmacy I designate as my primary pharmacy provider. In addition, Laredo Physicians Group will obtain the history of my past prescriptions from pharmacy benefit managers and I understand that those prescriptions will become part of my electronic health record. By signing below I hereby give consent to the above actions.

Signature of Patient or Legal Representative:____Date:_______________

CONSENT TO CALL

The Telephone Consumer Protection Act (TCPA) requires an individual to provide “express consent” for automated calls to mobile phone numbers. Laredo Physicians Group utilizes automated phone calls for reminder calls about upcoming appointments, group calls, results calls, and self-pay calls. Do you consent to receive automated phone calls on your mobile phone?: **YES** **NO**

Individuals have the right to request receipt of confidential communications from Laredo Physicians Group by alternative means or at alternative locations. If you have specific restrictions on how you would like Laredo Physicians Group to communicate with you, please make note of that here:

____

____

____

Signature of Patient or Legal Representative:____Date:_______________

LAREDO PHYSICIANS GROUP

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, you acknowledge that you have received the *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

____

____

Patient Name (print):______________________________________Patient Date of Birth:_______________

SIGNATURES:

Patient/Legal Representative: ________________________________ Date:______________

If Legal Representative, relationship to Patient: ____________________________________

Witness (optional) : ______________________________________Date:______________

ASSIGNMENT OF BENEFITS and RELEASE OF INFORMATION:

1) I acknowledge full responsibility for the payment of all professional services rendered for my care and agree to pay my bills in full AT TIME OF SERVICE unless other arrangements are made in advance. By signing this consent I assign all rights, title and interest and authorize direct payment to Laredo Physicians Group of any insurance benefits or benefits under the Social Security Act for the services. Laredo Physicians Group (IPM) will assist in billing my insurance company but I am financially responsible for charges not collected by this assignment. I authorize Laredo Physicians Group to bill my insurance or third party payor and receive payment from them directly. I understand that I am responsible for any amount not covered by insurance.

2) I acknowledge that to the extent necessary to determine liability for payment or to obtain reimbursement, Laredo Physicians Group may disclose my records to any person, Social Security Administration, insurance or benefit payor, healthcare service or plan, or worker's compensation carrier which is, or may be, liable for all or any of the charges. Furthermore, Laredo Physicians Group may disclose my records to other treating providers, health care providers, audit committees for the purpose of quality improvement, and applicable state and federal agencies.

3) My signature acknowledges that I have been given the right to ask questions and receive information about any services and I voluntarily sign this consent. A photocopy or a faxed copy of this authorization shall be deemed as valid as the original.

______________________________ ______________________

Patient/Responsible Party Signature Date

______________________________ ______________________

Witness Date

PRACTICE NOTICES

FINANCIAL AGREEMENT: The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/ or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits for services rendered without obtaining my signature on each claim submitted for myself and/ or dependents. I hereby authorize my insurance company to pay and hereby assign directly, Laredo Physician Care Clinic/ Mariela Bernal Irizarry M.D. Office. I further acknowledge that any insurance benefits, when received and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility in accordance with our contractual agreements with your insurance and when governed by state/federal law. Full payment is due at the time of delivery of service unless other arrangements have been made or mandated by law. I understand that I have the primary duty and obligation to pay my doctor for his/ her services, notwithstanding any contract I may have with any third party payer (i.e. insurance company, employer, etc.). I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement.

HIPAA Disclosure

Laredo Physician Care Clinic / Mariela Bernal Irizarry M.D. Office shall not publish or otherwise make generally available any protected individually identifiable health information or data that identifies a patient for purposes other than treatment, payment or other health care operations without his/ her express written consent. This does not restrict the internal use of such information or data that is required in the performance of the scope of work that this office has been engaged to perform for our patient's. This office maintains physical, electronic, and procedural safeguards to protect individually identifiable health information. As our patient you have the right to request special privacy protections. You have the right to request restrictions on certain uses and disclosure of your health information, by written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. I hereby acknowledge that this medical practices' Notice of Privacy Practices has been made available to me. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of this notice.

Signature of Patient or Responsible Party	If person signing is not patient, please state relationship	Date