DOC-AID™

PATIENT REGISTRTION INFORMATION

Date: Reason for Visit: _____

Is this a WORK related problem? [ ]YES [ ] NO Is this AUTO ACCIDENT related? [ ] YES [ ]NO

Patient Name: Last _____ First _____ MI ____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - ____ - _____ Email: _____@_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) - Cell Phone: ( ) - Other: ( ) -

Pharmacy Name:_____ Cross Streets: _____

Gender: [ ] Male [ ] Female

Race: [ ] Black [ ] Hispanic [ ] White [ ] Other: _____

Language: [ ] English [ ] Spanish [ ] Sign Language [ ] Other: _____

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

Marital Status: [ ] Single [ ] Married [ ]Widowed [ ]Divorced

Please notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about the patient's health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

Primary Care Physician: _____ Phone Number: (_____) _____ - _____

Emergency Contact: _____ Phone Number: (_____) _____-_____ Relationship:

Insurance Subscriber/Guarantor / Responsible Party (for patient under 18)

[ ] Is insurance subscriber's address different from above [ ] yes [ ] no

Last Name: _____ First Name: _____ MI: _____

Relationship to patient: [ ]Self [ ]Spouse [ ]Dependent [ ]Other

Date of Birth: _____ / _____ / _____ Guarantor Social Security #: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____Cell Phone: (_____) _____ - _____ other: (_____) _____ - _____

Guarantor Employer: Phone:

Primary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured Date of Birth: _____ / _____ / _____

Insured Social Security **#:** _____ - _____ - _____

Secondary Insurance Coverage

Insurance Company: _____ Name of Insured: _____

Relationship to Patient: _____ Insured Date of Birth: _____ / _____ / _____

Insured Social Security **#:** _____ - _____ - _____

Verification of Information: I verify that the above information provided is true and correct to the best of my knowledge.

X _____ Date: _____ / _____ / _____

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Name _____ **Race** _____ **Sex** _____ **Age** _____

Height _____ **Weight** _____

Present Concerns: _____

Past Medical History

Have you ever had:

Chicken Pox	____ No	____ Yes When ____		Hepatitis	____ No	____ Yes When ____	
Scarlet Fever	____ No	____ Yes When ____		Tuberculosis	____ No	____ Yes When ____	
Rheumatic Fever	____ No	____ Yes When ____		Pneumonias	____ No	____ Yes When ____	
Polio	____ No	____ Yes When ____		Venereal Disease	____ No	____ Yes When ____	
Blood Transfusions	____ No	____ Yes When ____					

Have you ever been treated for:

Asthma	____ No	____ Yes When ____		Thyroid Disease	____ No	____ Yes When ____	
Emphysema	____ No	____ Yes When ____		Diabetes	____ No	____ Yes When ____	
Heart Attack	____ No	____ Yes When ____		Anemia	____ No	____ Yes When ____	
Heart Failure	____ No	____ Yes When ____		Cancer	____ No	____ Yes When ____	
Heart Murmur	____ No	____ Yes When ____		Kidney Disease	____ No	____ Yes When ____	
Abnormal Heartbeat	____ No	____ Yes When ____		Kidney Stone	____ No	____ Yes When ____	
High Blood Pressure	____ No	____ Yes When ____		Ulcer Disease	____ No	____ Yes When ____	
Colitis	____ No	____ Yes When ____		Gall Bladder			
Blood Clots	____ No	____ Yes When ____		Disease	____ No	____ Yes When ____	
Arthritis	____ No	____ Yes When ____		Stroke	____ No	____ Yes When ____	
Gout	____ No	____ Yes When ____		Epilepsy(seizures)	____ No	____ Yes When ____	
Abnormal Cholesterol	____ No	____ Yes When ____		Psychiatric Disorder	____ No	____ Yes When ____	
Chronic Allergies, Hay Fever	____ No	____ Yes When ____		Glaucoma	____ No	____ Yes When ____	
				Colon Polyps	____ No	____ Yes When ____	

Other problems not listed above _____

Pharmacy of Choice _____ **Pharmacy Phone Number:** _____

List any operations that you have had (include approximate age): _____

List any medications (and dosages) you currently are taking (include over-the-counter drugs):

List medication allergies

Habits

Tobacco use? No_____ Yes_____ How many packs per day? _____
Did you quit? No_____ Yes_____ How many packs per years? _____
If so, When? _____
Alcohol? No_____ Yes_____ Amount per day? _____
Coffee, tea or cola? No_____ Yes_____ Amount per day? _____
Do you exercise regularly? No_____ Yes_____ How often? _____
What kind of work
do you do? _____ Any toxic exposure? No_____ Yes_____
What method of contraception do you use(if applicable)? _____

Do any of your family members have or have had:		**Family History:**	**Age**	**Illness**
Cancer	No_____ Yes_____	Father	_____	_____
Heart Attacks	No_____ Yes_____	Mother	_____	_____
High blood pressure	No_____ Yes_____	Brothers	_____	_____
Strokes	No_____ Yes_____	Sisters	_____	_____
Thyroid disease	No_____ Yes_____	Sons	_____	_____
Diabetes	No_____ Yes_____	Daughters	_____	_____
Anemia	No_____ Yes_____	Other	_____	_____
Kidney disease	No_____ Yes_____			
Ulcers	No_____ Yes_____			
Other	No_____ Yes_____			

Are you bothered with:

Skin Rashes or Discoloration	No_____ Yes_____	Loss of Consciousness(Fainting)	No_____ Yes_____
Abnormal Lumps or Glands	No_____ Yes_____	Unusual or Serious Visual Problems	No_____ Yes_____
Nausea or Vomiting	No_____ Yes_____	Hearing, Problems, Earaches	No_____ Yes_____
Belly Pain	No_____ Yes_____	Headaches	No_____ Yes_____
Constipation	No_____ Yes_____	Frequent Colds	No_____ Yes_____
Diarrhea	No_____ Yes_____	Hoarseness	No_____ Yes_____
Bloody or Tarry Stools	No_____ Yes_____	Frequent or Persistent Cough	No_____ Yes_____
Excessive or Constant Worrying	No_____ Yes_____	Feeling Lonely or Depressed	No_____ Yes_____
Abnormal Tiredness	No_____ Yes_____	Inability to Sleep Well	No_____ Yes_____
Shortness of Breath	No_____ Yes_____	Mood Swings	No_____ Yes_____
Wheezing	No_____ Yes_____	Poor Appetite	No_____ Yes_____
Chest Pain	No_____ Yes_____	Difficulty Swallowing	No_____ Yes_____
Skipped or Irregular Heartbeat	No_____ Yes_____	Hemorrhoids	No_____ Yes_____
Ankle Swelling	No_____ Yes_____	Trouble Urinating	No_____ Yes_____
Pain in your Legs when you walk	No_____ Yes_____	Arthritis	No_____ Yes_____
Weakness in your Arms or Legs	No_____ Yes_____	Morning Stiffness	No_____ Yes_____
Loss of Sensation (numbness)	No_____ Yes_____	Fever or Chills	No_____ Yes_____
Lightheadedness	No_____ Yes_____	Impotence or Other Sexual Difficulty	No_____ Yes_____
Night Sweats	No_____ Yes_____	Bruises	No_____ Yes_____
Weight Loss	No_____ Yes_____	Weight Gain	No_____ Yes_____

Please give details of any yes answers or of other symptoms not listed above _____

Please list any other doctors you currently see: _____

Female Patients - Do you have any problems with:

Cramps	No_____ Yes_____	Heavy Bleeding	No_____ Yes_____
Irregular	No_____ Yes_____	Discharge	No_____ Yes_____
Painful intercourse	No_____ Yes_____	Last Breast Exam/Mammogram	_____
Your last menstrual period?	_____	Last Pap Smear	_____
		Last Bone Density Scan	_____

Number of pregnancies and any complications _____

Signed _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for the Practice of DOC-AID.

_____	_____
Patient/Guardian Signature	Witness
_____	_____
Print Name of Patient	Patient's Date of Birth
_____	_____
Date of Signature	Date

Documentation of Failure to Obtain Signed Acknowledgement:

On _____, this Acknowledgement of Receipt of Notice of Privacy Practices was presented to _____ (the Patient/Guardian).

The Patient /Guardian refused to provide a signature when requested.

Privacy Officer:

Monica Saenz, M.D.
2438 Monarch Drive Suite # **A-375**
Laredo, TX
(956) 523-0966

Assignment of Benefits

I hereby assign to DOC-AID any insurance or other third_ party benefits available for health care services provided to me. I understand that DOC-AID has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to DOC-AID, I agree to forward to DOC-AID all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian:_____

Date: _____

DOC-AID™

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, IT IS YOUR RESPONSIBLITY TO MAKE CHANGES FOR PAYMENT OF THE VISIT OTHERWISE YOU WILL BE BILLED.
2. ALL insured patients are required to keep a credit card on file as a guarantee of payment for any patient-responsible balances after insurance processing.
3. Please be assured that we do not keep any credit card information on file or on any of the computers here in the office.
4. We use a secure gateway that is completely compliant, as required by the Payment Card Industry Data Security Standard (PCI-DSS).
5. The credit card number is securely stored on a remote server with Bluefin Gateway and is not visible to us.
6. You will receive a courtesy call or email for any balance above $100 before your card is charged for any remaining patient balance after your insurance plan has processed your claim.
7. If you choose to not keep a credit card on file, you will be charged as a CASH patient at the time of your visit.
8. As a CASH patient, your visit will not be processed with your insurance company.
9. This policy authorizes DOC-AID to charge the credit card on file for any patient-responsible balances for services received after insurance processing.
10. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
11. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
12. If DOC-AID do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
13. For ANY appointments, all prior balances must be paid prior to the visit.
14. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
15. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
16. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $10.00 re-bill fee. Any balance over 90 days will be forwarded to a collection agency.
17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Print Patient Name(s) _____

_____

Responsible party member's name Relationship

_____

Responsible party member's signature Date

Payment Policy

Thank you for choosing us for your urgent care neds. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be not covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

DOC-AID is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

DOC-AID™

Notice Concerning Complaints

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353.
For more information, please visit our website at www.tmb.state.tx.us

Aviso Sobre Las Quejas

Las quejas sobre médicos, asi como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugia, se pueden presentar en la siguiente dirección para ser investigadas:

Texas Medical Board Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353. Para obtener más
información, visite nuestro sitio web en www.tmb.state.tx.us.

I have read and understand the information provided as well as the procedure above regarding "Notice Concerning Complaints".

_____

Patient/Responsible Person Signature Relationship Date