**Patient Information Form**

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Text Message**: □ Yes □ No

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status**: □ S □ M □ D □ W

**Gender**: □ Female □ Male □ Transgender **Ethnicity**: □ Hispanic or Latino □ Not Hispanic or Latino

**Race**: □ American Indian or Alaskan Native □ African American □ Asian □ Pacific Islander □ White □ Other

**Email Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** □ Social Media □ Internet □ Family or Friend □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_ **Zip** **Code**: \_\_\_\_\_\_\_\_\_\_\_\_ **Work** **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Primary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy I.D.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group No.** \_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy I.D.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group No.** \_\_\_\_\_\_\_\_\_\_\_\_

**Policy Holder**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Text Message**: □ Yes □ No

**Work Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

*The individual who agrees to accept financial responsibility for the payment of all services performed at Laredo Premier Healthcare, PLLC. This individual may not necessarily be the insurance card holder. Responsible party must sign below*.

**Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M.I.** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Text Message**: □ Yes □ No

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pharmacy Information**

**Preferred Pharmacy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **RX History Consent (Initials)**: \_\_\_

\_\_\_\_\_\_ (Initial) **Cancellation Policy/No Show Policy**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we were unable to schedule you for a visit, due to a seemingly “full” schedule. If you cannot keep your appointment, you must notify the office within 24 hours to cancel.

If you miss your appointment without notifying our office, a charge of $25.00 will be generated for that missed appointment.

We reserve the right to reschedule your appointment if you are more than 15 minutes passed your scheduled appointment time.

If you have more than three (3) missed appointments, you will only be allowed as a “walk in” status.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Patient’s Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/Representative Relationship

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a written copy of Laredo Premier Healthcare’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship

**Acknowledgement of Notice of Patient Rights and Responsibilities**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a written copy of Laredo Premier Healthcare’s Notice of Patient Rights and Responsibilities.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Relationship

**Administrative and Financial Policies**

\_\_\_\_\_\_\_ (Initial) **Payments**

All patients are responsible for full payment at the time of service. This includes copay(s), co-insurance, deductibles. We accept cash, checks, and major credit cards (American Express, Discover, MasterCard, Visa). Postdated checks are not accepted.

\_\_\_\_\_\_ (Initial) **Private Insurance**

Although we will bill your insurance company, you are financially responsible for all services rendered. Should your health plan deny coverage for any reason, you will be responsible for payment in full. Insurance is a contract between you and your insurance company. The office will file insurance claims as a courtesy to our patients. We cannot become involved in disputes between you and your insurance company regarding deductibles, copays, etc. You are responsible for the timely payment of your account balance. If you have a copay or deductible, be prepared to pay it at the time of service.

\_\_\_\_\_\_ (Initial) **Patients Without Insurance**

Our fees cannot always be determined in advanced since they depend on services rendered. Full payment is due at the time of service.

\_\_\_\_\_\_\_ (Initial) **Medicare**

We will bill Medicare for you. You must, however, supply us with the most up to date and correct information at the time of your visit. You will be responsible for your deductible and copay. If you do not have a supplemental insurance, you will be responsible for payment of the 20% that Medicare does not pay.

\_\_\_\_\_\_ (Initial) **Texas Medicaid, QMB**

QMB Medicaid has limited benefits. Anything that is not covered by Medicare will not be covered by QMB. The patient will be responsible for payment at time of service.

\_\_\_\_\_\_ (Initial) **Texas Medicaid**

We are Medicaid providers for the state of Texas, but we do require that you bring your card with you at every visit to demonstrate monthly coverage. Please also be sure to provide a picture I.D. at the time of service. Anything that is not covered by Medicaid will be the patient’s responsibility.

I have read and fully understand the Patient Financial Policies as outlined above. I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I assumed responsibility by signing below from this date forward until it has been revoked in writing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Patient’s Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient/Representative Relationship

**\_\_\_\_\_\_\_** (Initial) **Personal Information**

Every patient is responsible for updating their personal information such as name, address, phone, and insurance as soon as possible.

\_\_\_\_\_\_\_ (Initial) **Account Balances and Credits**

Any pending or previous balances must be paid prior to any service rendered the day of the next appointment. Patients are notified of pending balance via statements.

\_\_\_\_\_\_\_ (Initial) **Disclosure of Information**

Dr. Luis M. Benavides, Dr. Alex Blanco, Dr. Cynthia Cantu, Dr. Eduardo Gomez-Vazquez, Dr. Jorge Gomez-Vazquez, and. Dr. Eloy Zamarron are required by law to disclose that they have an ownership interest in Doctor’s Hospital of Laredo and its affiliate clinics and outpatient services. In addition, Dr. Marisa I. Aguirre, Dr. Luis M. Benavides, Dr. Alex Blanco, Dr. Cynthia Cantu, Dr. Eduardo Gomez-Vazquez, Dr. Jorge Gomez-Vazquez, and Dr. Eloy Zamarron have ownership interest in Laredo Premier Healthcare, PLLC. I acknowledge that I have received full disclosure of ownership from the Laredo Premier Healthcare physicians.