

ZARATE MEDICAL GROUP, P.A.

WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to serve you properly we will need the following information. *All information will be strictly confidential.*

PLEASE PRINT

Last Name	First Name	MI	Maiden
Address			Apt #
City		State	Zip
Date of Birth	Age	SS #	Sex: <input type="radio"/> Male <input type="radio"/> Female
Phone # ()		Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed	
Alternate Phone # ()		Race	<input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic <input type="radio"/> Refused
Employer		Work Phone # ()	
Employer Address		Occupation	
Emergency Contact	Relationship	Phone # ()	
How were you referred to this office:			
Do you have an Advanced Directive: <input type="radio"/> Power of Attorney <input type="radio"/> Living Will <input type="radio"/> Other -			

Insurance Information – (Please allow our office to make copies of your current Insurance cards)

<input type="radio"/> Private Pay – Who will be responsible for paying on account, _____.		
<input type="radio"/> Primary Insurance	Insured	
Relationship of patient to Insured	Insured SS#	Date of Birth
<input type="radio"/> Secondary Insurance	Insured	
Relationship of patient to Insured	Insured SS#	Date of Birth

PAYMENT POLICY: All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. Billing information will be provided to expedite patient reimbursement from private insurance carriers.

CO-PAYMENT OR FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

The undersigned authorizes to release any information relating to all claims for benefits submitted for myself or dependents and agree that my signature below authorizes claims submitted for services rendered. I hereby authorize my insurance company to pay and assign directly to Zarate Medical Group, P.A. all reimbursement benefits payable under my insurance policy.

I understand that I am financially responsible for all charges incurred, and if that insurance does not pay within 45 days, the balance is due from me.

I hereby authorize Zarate Medical Group, P.A. to release by mail, telephone, fax any medical or incidental information that may be necessary for either medical care or processing applications for financial benefits.

I certify that that information given by me is correct. I understand that fees for all services provided by Zarate Medical Group, P.A. are due at the time services are rendered unless other arrangements have been made.

(Authorized signature of Patient, Insured and/or Guardian)

Date

AUTHORIZATION TO LEAVE MESSAGES ON ANSWERING MACHINES

Please initial your choice

_____ **I DO NOT AUTHORIZE** the practice to leave messages on any personal telephone numbers listed

_____ **I AUTHORIZE** the practice to leave messages on the personal telephone numbers listed **OR** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS OR FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability and Accountability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

_____ **I DO NOT AUTHORIZE** the practice to release any or all information concerning my medical condition to any individual or organization not involved in Treatment, Payment or Healthcare Operations as related to care or services provided by Zarate Medical Group, P.A.

_____ **I AUTHORIZE** the practice to **VERBALLY** release any or all information concerning my medical condition to the individual(s) or organization(s) listed below (In addition to any involved in Treatment, Payment or Healthcare Operations as related to care or services provided by Zarate Medical Group, P.A.

_____ Name

_____ Relationship to Patient / Phone #

_____ Name

_____ Relationship to Patient / Phone #

_____ Name

_____ Relationship to Patient / Phone #

_____ Name

_____ Relationship to Patient / Phone #

_____ Patient (or Legally Responsible Party's Signature)

_____ Date

_____ Witness

_____ Date

ZARATE MEDICAL GROUP, P.A.

Zarate Medical Group would like to welcome you to our office. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read, initial and sign at the bottom.

Please initial each line

_____ 1. **PAYMENTS.** All applicable fees, deductibles, coinsurance, co-pays and account balances must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard, Discover or American Express. There will be a \$30.00 charge for returned checks.

_____ 2. **CANCELLATIONS.** If you need to cancel your appointment, be sure to call at least 24 hours before your scheduled appointment.

_____ 3. **CHANGE OF INFORMATION.** Please provide us with any change regarding your address, phone number or insurance information as soon as possible.

_____ 4. **AFTER HOURS CARE.** A Zarate Medical Group Physician is on-call 24-hours each day. If you have a life-threatening emergency, do not call the office, dial 911. If you have a non-life threatening emergency, call our office at (210) 587-8787 and the on-call physician will be notified.

_____ 5. **NON-COMPLIANCE.** We reserve the right to discontinue care with our office for non-compliance with any of the above policies.

I, the Guarantor of Payment and Responsible Party, agree to the above policies and agree to the terms regarding payment and payment responsibilities.

Signature

Date

Printed Name

Witness' Signature