WESLACO MEDICAL CLINIC
DR. PEDRO J. PENALO
906 S. BRIDGE
WESLACO, TX 78596
(956) 447-8600 FAX: (956) 447-0335

When registering, please present proof of insurance, Medicare and /or Medicaid. Payment is **expected** at the time of service unless special arrangements are made. Al registrarse, por favor presente la prueba de seguro, Medicare y Medicaid y/o. Pago se **espera** que en el momento de servicio a menos que se adopten disposiciones especiales.

Patient information:

Name/Nombre: _____ Sex: (F) _____ (M) _____
Address/Direccion: _____
City/Ciudad: _____ State/Estado: _____ Zip: _____
Home Phone/Telefono: ( ) _____ Cell Phone/Telefono: ( ) _____
Date of birth/F de Nac: _____ Age/Edad: _____
Soc. Sec. Number/Num. de Seg. Soc. _____ Drivers license/ licencia# _____

Patient's employer:

Employer/Trabajo: _____
Occupation/ocupacion: _____
Address/Direccion: _____ Phone/Telefono: ( ) _____
City/Ciudad: _____ State/Estado: _____ Zip: _____

Patient's insurance information:

Insurance company name/Nombre de asegurado: _____
Policy/Policia# _____ Subscriber/Supscritor # _____

Spouse:

Name/Nombre: _____
Cell phone/Telefono: _____ Work phone/Telefono: _____
Employer/Trabajo: _____ Occupation/ocupacion: _____

Emergency Contact/A quien notificar en caso de emergencia:
(Not living with you/No viven con usted)
Name/Nombre: _____ Relationship/Relacion: _____
Address/Direccion: _____ City/Ciudad: _____ ,
StateEstado: _____ Zip: _____
Home phone/Telefono: _____ Cell phone/Telefono: _____

How did you learn of our practice? / Quien lo refirio a este consultorio? _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered my insurance. Certifico que la información anterior es correcta a lo mejor de mi conocimiento. También entiendo que soy financieramente responsable por todos los cargos o no cubiertas mi seguro.

Signature: _____ Date: _____

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS INFORMATION CAREFULLY.

This notice is to inform you that your confidential healthcare information may be disclosed for purposes of treatment, payment for services and during healthcare operations. It also describes your rights to access and control your confidential healthcare information.

Uses and Disclosures of Protected Health Information:
Your confidential information may be disclosed by your physician, our office staff and others outside our office for continuation of quality healthcare. Your confidential information cannot be disclosed for purposes other than those which our outlined in this notice.

Treatment: Our office will use and disclose your confidential health information to provide, coordinate or manage your healthcare and any related services. This may include coordination or management of your healthcare with a third party and or during an emergency. For example we would disclose your confidential information, as needed, to another physician who we may refer you to, a home health agency or a rehab agency that will provide care to you. This information is given with the intent the physician or agency has the necessary information to diagnose or treat you.

Payment: Your confidential information will be used, as needed, to receive payment healthcare services that have been provided to you. For example obtaining approval for a hospital stay may require to disclose confidential information to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose your confidential information during our regular business activities. This activities include but our not limited: quality assessment, employee review activities, and training of medical or physician assistant student. For example we may disclose your confidential information to medical or physician assistant students that see patients in our office. In addition, we will also call you by name in the waiting room when your physician is ready to see you and you may be contacted by office personnel to remind you of your appointments, healthcare treatment options or other health care services that be of interest to you.

We may use or disclose your confidential healthcare information without your authorization in the following situations. As required by law, this situation include public health issues such as, communicable diseases, defective devices or a food or medication reaction. Your confidential information may also be disclosed to public offices or law enforcement agencies in an investigation in which you are victim of abuse, a crime or domestic violence.

Your Rights:

The following is a statement of your rights with respect to your confidential health information. You have the right to restrict the use of disclosure of your confidential health information. This means that you have the right to restrict family members, friends or others involved in your healthcare services from your confidential information. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician may choose not to agree with your request if he believes its in your best interest to permit use and disclosure of your information or during an emergency. You have the right to look for another Healthcare Provider.

You have the right to receive confidential communication about your healthcare status and have the right to request a copy of any and or all portions of your healthcare information. In addition, you also have the right to know who has obtained your confidential information and for what reason you have the right to request changes to be made to your confidential information.

You have the right to have a copy of this Privacy Notice upon your request. In addition, we reserve the right to make changes to this notice and to continue to maintain the confidentiality of all healthcare information. The physician office is required by law to protect the privacy of its patients.

Complaints:

You may complain to the Privacy Officer of this office, Dr. Pedro Penalo and 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 mail your complain to :

ATTN: Privacy Officer
Weslaco Medical Clinic
906 S. Bridge Ave.
Weslaco, TX 78596

All complaints will be investigated. We will not retaliate against you for filling a compliant. If you have any questions about this Privacy Notice, please contact the Privacy Officer at (956)447-8600.

I have read this Privacy Notice and was given an opportunity to object to disclosures of my confidential health information.

_____

Patient's Signature

_____

Witness

Date: _____

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MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf Dr. Pedro J. Penalo or any services furnished me by this physician. I authorize any holder of medical information about me to release the Centers for medicare and medicaid and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I "other health insurance" is indicated in item 9 of the HCFA-1500 form, elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in medicare assigned cases, the physician or supplier agrees to accept the charge determination of the medicare carrier as the full charge, and the patient is only responsible for the deductible, co-insurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the medicare carrier. I have received a copy of the Privacy Notice and have been given an opportunity to object to disclosures of my health information.

AUTORIZACIÓN DE MEDICARE

Solicito que el pago de beneficios autorizados de Medicare se bien a mí o en mi nombre el Dr. Pedro J. Penalo o cualquier servicio proporcionado por la presente mi médico. Yo autorizo a cualquier titular de la información médica acerca de mí para liberar los Centros de Medicare y Medicaid y sus agentes cualquier información necesaria para determinar estos beneficios o los beneficios pagaderos para servicios relacionados. Entiendo que mi firma pide que se pague y autoriza la liberación de la información médica necesaria para pagar la reclamación. I "otro seguro de salud" está indicado en el punto 9 de la forma HCFA-1500, aprobado en otros lugares en otros formularios de reclamación o reclamaciones presentadas por vía electrónica, mi firma autoriza la liberación de la información a la aseguradora o el organismo se muestra en los casos de enfermedad asignado, el médico o proveedor se compromete a aceptar la determinación de la carga de enfermedad como el transportista carga completa, y el paciente sólo es responsable de los deducibles, co-seguro, y noncovered servicios. Coseguro y el deducible se basan en la determinación de la carga de enfermedad transportista. He recibido una copia de la Notificación de Privacidad y se les ha ofrecido la oportunidad de oponerse a la divulgación de mi información de salud.

Beneficiary Signature _____ Date _____

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ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with/_____ and assing Dr. Pedro J. Penalo, M.D. medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I acknowledge that I have been provided with a Privacy Notice and was given an opportunity to object to the disclosure of my protected health information.

ASIGNACION Y AUTORIZACION

Yo, el abajo firmante, tiene cobertura de seguro con / _____ Assing y el Dr. Pedro J. Penalo, MD prestaciones médicas, en su caso, de otro modo pagadero a mí por los servicios prestados. Entiendo que soy financieramente responsable de todos los cargos o no pagado por el seguro. Por la presente autorizo al médico para liberar toda la información necesaria para garantizar el pago de las prestaciones. Yo autorizo el uso de esta firma en todas mis presentaciones de seguros. Reconozco que he sido provisto de una Notificación de Privacidad y se le dio la oportunidad de oponerse a la divulgación de mi información protegida de salud.

_____ _____

Signature of Insured Date

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Acknowledgment to review of
Notice of Privacy Practice

I have reviewed this office 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.

_____ _____

Signature of Patient/Personal Representative Name of Patient

_____ _____

Date Description of Personal Reps Auth.

Reconosimento de reviso de
Aviso de Prevacidad

Yo e revisado las nota de privacidad de esta oficina, por medios de la qual se me esplico como mi informacion medica va ser usada y compartida. Yo entiendo que derecho de recibir una copia de este documento.

_____ _____

Firma de paciente/ representate del paciente Nombre de pacente

_____ _____

fecha Descripcion de la authoridad de representante

Weslaco Weslaco Medical Clinic
906 S. Bridge Ave.
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____

Social Security Number_____ Date of Birth_____

_____I authorize the medical practice of Dr. Pedro Penalo.MD to make the disclosure
The type and amount of information to be used or disclosed is as follows:(include dates where appropriate)

_____Physician Progress Notes_____(dates)
_____History & Physical_____(dates)
_____Laboratory Results_____(dates)
_____Radiology Results_____(dates)
_____Pathology Results_____(dates)
_____EKG Reports_____(dates)
_____Entire Record_____(dates)
_____Others_____(dates)

1. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) or human Immunodeficiency virus(HIV). It may also include information about behavioral or mental health services. And treatment for alcohol and drug abuse.

2. This information may be disclosed to and used by the following individual or organization:

   Name of Person/Organization_____

   Address_____City_____State_____Zip_____

3. I understand that I have the right to revoke this authorization at any time. I understand that if I Revoke this authorization I must do so in writing and resent my written revocation to the Office Manager. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or _____condition. If I fail to specify an authorization date, event or condition, this authorization will expire In 180 days.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to Sign this authorization. I need not sign this form on order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed as provided CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Date
Relationship to Patient