Teresa R. Pinaroc, M.D., P. A.

11548 Vista Del Sol Dr
El Paso, Texas 79936
Tel: (915) 613-3741
Fax: (915)594-0566

_____
Date

Patient's name : _____ ***Date of Birth:***_____

Names and phone #'s of doctors whom you have seen in the past 12 monts or who has prescribed medications for you.

1. _____
2. _____
3. _____
4. _____

Please list all of the medications along with the dosage which you are taking including over the counter drugs, herbs, and vitamins

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(continue on back if more space is needed.)

Drug / Food Allergies:_____

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_____
Date

Patient's name : _____

The last time I had the following screening test was:

1. ***Female patients: Last pap smear? Date (mm/yy) and Where***

_____

2. ***Female patients: Last mammogram? Date (mm/yy) and Where?***

_____

3. ***Who ordered your last cholesterol check? Date (mm/yy)?***

_____

4. ***Who performed your last colonscopy? Date (mm/yy)?***

_____

5. ***Have you had a Bone Density test? Where?***

_____

6. ***<u>MEN</u>: Date (mm/yy) of last PSA done? Who ordered it?***

_____

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11548 Vista Del Sol Drive
El Paso, Texas 79936
(915) 613-3741 (Appointment Scheduling)
(915) 594-0566 (Fax) Website: **www.adultmedclinic.com**

WELCOME TO OUR PRACTICE

This packet is to introduce you to our office and our policies. We will ask you to sign an acknowledgement that you have received and understand the policies

ABOUT YOUR CARE

Your on-going care is a very personal and important matter. We encourage each of our patients to take an active role in understanding their care and treatment. If at any time during the course of your treatment you do not understand any facet of your care, or if you would like to know more about your particular condition, please do not hesitate to ask Dr. Pinaroc, or the staff.

SCHEDULING AN APPOINTMENT

All visits to our offices are by appointment only. To schedule an appointment or to speak to someone regarding your care, call us at (915) 613-3741. When scheduling an appointment, please describe the reason for your visit, if at all possible, so that an appropriate appointment time can be scheduled based on your condition. If you have an urgent medical condition, we will try our best to accommodate you by scheduling an appointment as soon as required by your condition.

If you are unable to keep your appointment, *please notify the office within at least 24 hours to avoid a* ***$25 no show fee***. When canceling appointments for a Monday please call by Friday morning, as we are not open on weekends. *You may leave a message to cancel an appointment* ahead of time in order to avoid the no show penalty.

PRACTICE HOURS

Teresa R. Pinaroc, M.D., P.A. is located at 11548 Vista Del Sol Drive.
Our office hours are 8:30 am to 3:30 pm, Monday thru Thursday, and 8:30 AM to 12:00 Noon Fridays. *We are closed on Saturdays & Sundays.*

IN CASE OF EMERGENCY

Urgent phone calls will be taken by our staff during office hours or immediately forwarded to Dr. Pinaroc by our answering service while we're closed. Please remember however, that a *$ 25 fee will be charged to your account in case of non-urgent phone calls addressed to the doctor after clinic hours , on holidays , or during weekends.*

You may also utilize nearby Urgent Care Clinics if you need to be seen for a non-emergent medical condition after hours (ie Family Urgent Care Center ph#857 4559 or Eastside Medical Care Center ph # 590 9424).
For life threatening emergencies , pls call 911 or proceed to the nearest emergency room.

INSURANCE FORMS

Insurance forms for your office and hospital care are completed at no charge to you by our in-office insurance department. However, some insurance companies require their own forms and it is your responsibility to provide these for us.

Our office accepts Medicare assignments, and our policy is to file a claim for you for the charges you have incurred with us. Medicare will pay us directly within four to five weeks. It will be your responsibility to pay the balance of the account at the time of service, unless you have made other arrangements with our business manager. Also, please understand that while we are happy to file your claims with your insurance company, the responsibility for payment of any uncovered charges is still yours. Our financial policy is included in this packet for your review and signature.

YOUR REFERRALS

Referrals of your family, friends and neighbors to our practice are the highest compliment we can receive and we sincerely appreciate your support and recommendation.

Thank you for choosing Teresa R. Pinaroc, M.D., P.A. for your healthcare needs. We value your confidence and are committed to providing you with the most comprehensive health care services. Your health is always our number one concern.

Updated 03/26/09 EFP

Teresa R. Pinaroc, M.D., P.A.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. *Teresa R. Pinaroc, M.D., P.A.* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

   a. For treatment –

      Copies of patient's lab results are sometimes requested by the patient's Specialist (e.g. Cardiologist, Surgeon, etc.)

   b. For payment –

      Some insurance companies may request a copy of the patient's progress notes, lab results, or x-ray films to ascertain whether the company will reimburse a claim.

   c. For health care operations –

      Labs or x-ray facilities may request other appropriate diagnosis prior to performance of certain blood work or radiographic studies to assure payment for their services.

2. *Teresa R. Pinaroc, M.D., P.A.* is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Please contact the Privacy Official for a list of these circumstances.

3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.

4. *Teresa R. Pinaroc, M.D., P.A.* intends to engage in one or more of the following activities:

   a. *Teresa R. Pinaroc, M.D., P.A.* may contact the individual to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to the individual or patient.

   b. *Teresa R. Pinaroc, M.D., P.A.* may contact the individual/Patient to collect overdue service fees for *Teresa R. Pinaroc, M.D., P.A.*

5. The Individual has the following rights regarding protected health information:

   a. The right to request restrictions on certain uses and disclosures of protected health information. *Teresa R. Pinaroc, M.D., P.A.* is not required to agree to a requested restriction, however.

   b. The right to receive confidential communications of protected health information, as applicable.

   c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

   d. The right to amend protected health information, as provided in the Privacy Regulation.

   e. The right to receive an accounting of disclosures of protected health information.

   f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. *Teresa R. Pinaroc, M.D., P.A.* is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.

7. *Teresa R. Pinaroc, M.D., P.A.* is required to abide by the terms of the Notice currently in effect.

8. *Teresa R. Pinaroc, M.D., P.A.* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.

9. *Teresa R. Pinaroc, M.D., P.A.* will provide individuals or patients with a revised Notice by *written notice*.

10. Individuals may complain to *Teresa R. Pinaroc, M.D., P.A.* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. A brief description of how the individual may file a complaint follows:

    a. Request a copy of the Privacy Rights complaint form from the Privacy Official. Fill out the form. Send the form to the Privacy Official.

    b. Express your grievance in a letter. Provide details of the complaint, information on how we may contact you. Send your letter to the Privacy Official.

    Privacy Official will respond to your complaint within 30 days.

11. *Teresa R. Pinaroc, M.D., P.A.*'s contact person for matters relating to complaints is:

    a. Ed Pinaroc, Office Consultant

    b. Phone: (915) 613-3741

    c. Address: 11548 Vista Del Sol Drive

    El Paso, Texas 79936

12. This Notice is first in effect on April 17, 2003.

12. *Teresa R. Pinaroc, M.D., P.A.* elects to limit the uses or disclosures that it is permitted to make, as follows:

    The patient must authorize the uses or disclosures of his/her Protected Health Information.

Patient Information Sheet Date:_____

Social Security # _____

Title (Dr.,Mr.,Mrs.,Ms) _____ Social Security # _____

Patient Name (First, MI, Last) _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Gender M___F___ Date Of Birth _____ Race_____

Single____Married____Widowed____Separated____Divorced___

Home Phone _____Cell Phone _____

Driver's License # _____ State _____ Occupation _____

Employer's Name _____

Employer Address 1 _____

Employer Address 2 _____

City _____ State _____ Zip _____

Employer Phone _____Ext _____

Spouse's Name _____Bithdate _____

Occupation _____Spouse's Employer _____

In Case Of Emergency, Contact:

Name _____Relationship _____

Home Phone _____Work Phone _____

Your Drugstore's Name /Address/Phone # _____

How did you learn of our practice?_____

Teresa R. Pinaroc, M.D.,P.A.

11548 Vista Del Sol Drive
El Paso, Texas 79936
(**915) 613-3741 Fax (915) 594-0566**

ACKNOWLEDGMENTS OF RECEIPT

This is to acknowledge that I have received a copy of the Teresa R. Pinaroc, M.D., P.A. "Welcome To Our Practice" informational brochure.

I also hereby acknowledge that I have received a copy of "*Teresa R. Pinaroc, M.D., P.A.*'s Notice of Privacy Practices" brochure.

I have read the brochures and understand the policies of the practice and my privacy rights.

_____

Patient Signature

_____

Print Name

_____

Date

Medical History

Name/Nombre_____

Allergies to Medication/Alergias de Medicina_____

Current Medical Problem/Problemas Medicos_____

Current Medications/Medicinas Que Esta Tomando_____

Surgeries or Hospitalization/Cirrugias o Hospitalizaciones_____

Are you Pregnant/Esta Embarazada __Yes/Si __No Nursing a child/Esta Amamantando __Yes/ Si __No

Do you Smoke.Fumar ____Yes/Si ____No Years/Anos_____ How Much/Cuanto_____

Do you drink alcohol/Tomar alcohol __Yes/Si __No How many drinks per week/Bebidas por semana____

Personal Medical History…. Have you ever had any of the following.

___Chest Pain/ Pressure/Tightening/Dolor de Pecho
___Hypertension/Alta Presion
___Heart Attack/Ataque del Corazon
___Stroke/Emolio
___Headache/Dolores de Cabeza
___Memory Loss/Perdida de Memoria
___Eczema/Problemas del Piel
___Difficuly hearing/Problemas del oido
___Asthma/Asma
___Dizzy/Mareos
___Cancer
___Diabetes

_____Allergies
_____Glau coma
_____Kidney Dz/Infermedad del Rinon
_____Shortness of Breath/Corta Respiracion
_____TB/Lung Doisorder/Disorden Pulmonar
_____Ulcers/Ulceras
_____Hepatitis
_____Blood in Stool/Sangre en escremento
_____Cataracts
_____Digestive Problems/Problemas Digestivo
_____Depression
_____Arthritis

Family History	Father/Padre	Mother/Madre	Father Parents/ Padres del Padre	Mother's Parents/ Padres del Madre	Siblings/ Hermanos
High Blood Pressure/ Alta Presion	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Heart Attack/ Ataque Del Corazaon	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Asthma/Asma	_____	_____	_____	_____	_____

Do you have a Advance Directive? ____Yes/Si ____No

Has an Advance Directive been discussed? ____Yes/Si ____No

Consent to Treatment

I (or my legal guardian or parent) authorize Teresa R. Pinaroc, M.D. to provide medical care reasonable by today's standards.

Signature of Patient/Legal Guardian: _____

Date: _____

Patient Consent Form

By signing this form, you are granting consent to Teresa R Pinaroc M.D., P.A. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by Contacting our office and directing any question to the Office Manager.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature:_____

Date:_____

Insurance Information

Who is responsible of this account?_____

Relationship to Patient:_____

Birthdate:_____SS#:_____

Insurance Co.:_____

Group #:_____

Is patient covered by additional insurance? Yes____ No____

Subscriber Name:_____

Birthdate:_____SS#:_____

Relationship to Patient:_____

Insurance Co.:_____

Group #:_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____
Name of Insurance Company

and assign directly to Dr._____all 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 insurance submissions.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration 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. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or 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 responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

STATEMENT OF FEE AND METHOD OF PAYMENT

This form is utilized to establish a clear understanding regarding the details of your financial account with this practice. Please read it, and do not hesitate to ask any questions. Your signature is an acknowledgment of your understanding and agreement with the provisions of this agreement.

Name of Patient: _____ Date: _____
Name of Responsible Party: _____ SSN: ____
_____
Relationship to Patient: _____

I, _____, agree to be responsible for payment in full of the charges for professional services, which have been rendered to the above-mentioned patient by Teresa R. Pinaroc, M.D., P.A. I also understand and agree to the following provisions regarding the fee and method of payment:

1. Teresa R. Pinaroc, M.D., P.A. will file primary insurance claims on behalf of the patient for rendered services. Insurance payment shall be made directly to the practice. Should any payment be made to the Responsible Party or any other individual, the Responsible Party agrees to promptly forward payment to the Practice.
2. The patient or Responsible Party will supply to the Practice any insurance forms that may be necessary to expedite the insurance filing process.
3. The Responsible Party shall pay the co-insurance payment (co-payment) at the time of each service. The co-payment is that part of the fee which is not covered by insurance after the deductible has been paid, or it is the amount that your managed care company (HMO, PPO, etc.) specifies as your personal payment for each appointment.
4. The Responsible Party shall pay any outstanding balance, which is not covered by insurance. The Responsible Party shall also pay claims or any part thereof which are denied or unpaid by an insurance company for any reason, such as for deductible, co-payments, unfiled claims, preexisting conditions, etc. irrespective of who is responsible for the denied claim or the uncovered service. The patient or Responsible Party may receive a statement whenever there is an outstanding balance. The Responsible Party, not the insurance company, is ultimately responsible for payment for the rendered services.
5. If for any reason the account becomes 90 days past due, the Responsible Party or the patient may be billed and expected to bring the account current. Please remember that we file insurance as a courtesy to our patients, and that your insurance contract is between you and your insurance company. We consider payment, therefore, to be the responsibility of the patient if a delay occurs from the insurance company. You will be expected to pay any balance not paid by your insurance company, or which your insurance company delays beyond 90 days after the date of service.
6. **You will be charged a minimum of $25.00 if an appointment is missed or canceled with less than 24 hours notice**. Insurance will not cover this charge. Full payment for a late cancellation or a no show must be made prior to or at time

of your next visit. We do not accrue no show or cancellation fees. Monday appointments must be canceled no later than 12:00 noon on the preceding Saturday. **A *medical emergency requiring documented treatment by a physician or a death in the immediate family are the only exceptions to this policy*.** If you cannot come to the office for other reasons, you have the option of rescheduling your appointment for the same calendar week, if your physician has an available opening.

7. Only the business manager is authorized to modify this agreement, or to make any financial arrangements between the practice and the patient. Physicians are specifically excluded from making any financial arrangements with patients.
8. I hereby authorize Teresa R. Pinaroc, M.D., P.A. to provide my insurance company with any clinical or financial information, which they may require.
9. Additional details or considerations regarding the method of payment may be outlined below:

_____
_____
_____

_____ _____
Signature of Responsible Party Date

_____ _____
Signature of Business Manager Date

TERESA R. PINAROC, M.D., P.A.
11548 Vista Del Sol Drive
P.O. BOX 961509
El Paso, Texas 79996
Phone: (915) 594-0565, (915) 613-3741
Fax: (915) 594-0566, (915) 400-5922
Email: adultmedclinic@yahoo.com
Website: www.adultmedclinic.com
CONFIDENTIAL

Authorization To Release Protected Health Information (PHI) In compliance with the Health Insurance Portability and Accountability Act By Electronic Mail

PATIENT NAME: _____

DATE OF BIRTH: _____

EMAIL: _____

I hereby authorize Teresa R. Pinaroc M.D., P.A., to use electronic mail to disclose to me my individual identifiable health information as described in the following list: messages, laboratory and radiology results, appointment reminders, orders, referrals, and other pertinent correspondence.

SIGNATURE: _____

DATE: _____