Dr Octavio E. Guzman

Thank you for choosing our office!

In order to serve you properly, we need the following information.
Please **PRINT**. *All information is confidential.*

Date:_____

Name: _____ SSN: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home phone: _____Work Phone _____Cell Phone_____

Check appropriate box: ( ) Minor ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

Emergency Contact: _____ Phone_____

EMPLOYER INFORMATION

Patient's or parent's (if minor) employer: _____Work phone:_____

Business address: _____City: _____ State: _____ Zip :_____

Spouse or parent's name (if minor): _____ Employer: _____

Phone:_____

RESPONSIBLE PARTY

Name of person responsible for this account (if different from patient's): _____

Relationship to patient: _____ Birthdate: _____ Home phone: _____

Cell Phone: _____ Address (if different): _____

Diver's license #: _____ State: _____

Employer: _____ Work phone: _____

INSURANCE INFORMATION

Name of primary insured: _____ Birthdate: _____ SSN: _____

Insurance company: _____ ID:_____Group: _____

Insurance company address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____ Work phone: _____

Name of employer: _____ Occupation_____

Date employed: _____Address of employer: _____

How much is your deducible? $_____How much have you used? $_____ Maximum annual benefit?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE ( ) YES ( ) NO

IF YES PLEASE COMPLETE THE FOLLOWING.

Name of primary insured: _____ Birthdate: _____ SSN: _____

Insurance company:_____ ID:_____Group: _____

Relationship to patient: _____ Work phone: _____

Name of employer: _____ Occupation_____

Date employed: _____Address of employer: _____

City: _____State: _____ Zip:_____

Insurance company address: _____Phone_____

City: _____ State: _____ ZIP :_____

Deductible? $: _____ How much used? $: _____ Maximum annual benefit? $:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize Dr. Octavio E. Guzman MD, PA to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Octavio E. Guzman (or to the party who accepts assignment). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

I certify that the information I have reported with regard to my insurance coverage is correct and I further understand it is my responsibility to advise the office of a change in insurance plan.

DATE: _____ SIGNATURE: _____

OFFICE FINANCIAL POLICY

Basic Policy: Payment is due in full at the time service is provided.

Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of the service. Since your agreement with your insurance company is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Initial _____

Medicare Patients: We will bill Medicare for you. We will also bill your secondary for you. All copayments and deductibles are due and payable at the time service is provided**.**

I have read and understood, and agree to the above financial policy for payment of professional fees.

I understand that I AM RESPONSIBLE FOR COLLECTION AND ATTORNEY FEES IF MY BILL IS NOT PAID IN A TIMELY FASHION.

DATE: _____ SIGNATURE: _____

Dr Octavio E. Guzman

6826 Springfield Ave Ste 101, Laredo, Texas 78045 (956) 717-1775

Confidentiality Policy

Name_____DOB_____

Appointment Reminders

Where can we contact you? _____

Home:_____ Work:_____

Cell: _____

If you are not available can we leave a message at your home?_____

Cell?_____, Work?_____

Messages

If we need to get in touch with you and you are not available can we leave a message at your home?_____ Cell?_____, Work?_____

Routine Continuity of Care

What other physicians are we allowed to give medical information to? (Including labs and office notes)

Further instructions to help us guard your privacy?

_____
_____
_____
_____

_____ _____ _____

Name (please print) Signature Date

_____

Witness

Dr. Octavio E. Guzman

6826 Springfield Ave Suite 101, Laredo, Texas 78041
(956) 717-1775 Fax (956) 717-1725

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Octavio E. Guzman M.D.,P.A's health care operations. The Notice of Privacy Practices also describes my rights and Octavio E. Guzman M.D., P.A.'s duties with respect to my protected health information. The Notice of Privacy Practices is posted in Dr. Guzman's office at 6826 Springfield Ave. Ste 101, Laredo, Texas 78041.

Octavio E. Guzman M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

Dr Octavio E. Guzman

*6826 Springfield Avenue Suite 101*Laredo, TX 78041*(956)717-1775*

Patient Medication Policy

In order to provide the outmost in patient health care we ask that our patients bring all of their current medications whether they are prescribed by Dr. Guzman, your primary care physician or over the counter medications. Failure to bring your medications with you at the time of your appointment may result in a delay in prescription/refill processing.

I, _____ have read and understood the Patient Medication Policy.
I understand that failure to bring my medications with me at the time of my appointment may result in a delay in the processing of my prescriptions/refills.

_____

Patient Signature Date

6826 Springfield Avenue Suite 101*Laredo, TX 78041*(956) 717-1775

Cancellation Policy/ No Show Policy
For Doctor Appointments

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 when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

Effective May 1, 2012, if an appointment is not cancelled at least 24 hours in advance, Octavio E. Guzman MD, PA. reserves the right to bill you 25.00 for each no-show and late cancellation. This fee will be your responsibility and will not be billed to your insurance.

In addition to the 25.00 fee with each missed appointment – we will notify you if you have missed three (3) or four (4) appointments to remind you of our policy. Additionally, we reserve the right to terminate our relationship with you after five (5) occurrences. Good medical care and a positive doctor- patient relationship are dependent upon consistent consultation and treatment. This cannot be accomplished with frequent missed appointments.

We understand that delays can happen however we must try to keep the other patients on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

To cancel or reschedule an appointment please call our practice during business hours or leave a message with our answering service at our office number (956) 717-1775.

We thank you for working with us to ensure services are provided to you in the best possible way.

_____ _____ _____

Name of Patient **Signature of Patient** **Date**