

DELACOTERA HEALTH CARE ASSOCIATION

129 Vision Park Blvd., Shenandoah TX 77384

Phone: (281) 248-8872 Fax: (281) 248-8875

Email: support@delacotera.com

PATIENT PERSONAL INFORMATION

NAME: _____ **DOB:** _____

SOCIAL SECURITY: _____ **SEX:** F ___ M ___

MARITAL STATUS: _____

ADDRESS: _____

PHONE: _____ **CELLPHONE:** _____

EMERGENCY : _____ **WORK:** _____

RACE: _____ **LANGUAGE:** _____

EMAIL: _____

IN CASE OF EMERGENCY

CONTACT NAME: _____ **RELATIONSHIP:** _____

PHONE: _____

EMPLOYER

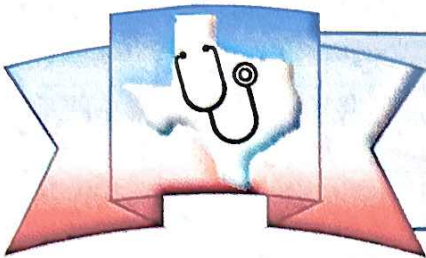
WORKING PLACE: _____ **WORK PHONE:** _____

WORK ADDRESS: _____

PHARMACY: _____ **PHONE:** _____

ADDRESS: _____

HOW YOU KNOW ABOUT US: _____



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AUTHORIZATION TO RELEASE INFORMATION ABOUT PATIENT'S CONDITION/ TREATMENT

Dear Patient:

In accordance of the Medical Privacy act of Texas, the physician and/or staff of Dr. Rodrigo Delacoter's office are unable to release and /or obtain any information pertaining to your condition, treatment, and/or care without your consent. If you authorize us to release and/or obtain information regarding your care to anyone other than yourself, please complete the following authorization.

I hereby authorize the physician and/or staff of Dr. Rodrigo Delacotera's office to release and/or obtain information pertaining to my condition and/or care to only those family members and/or others involved with my care as listed below:

NAME

RELATIONSHIP

NAME

RELATIONSHIP

Messages

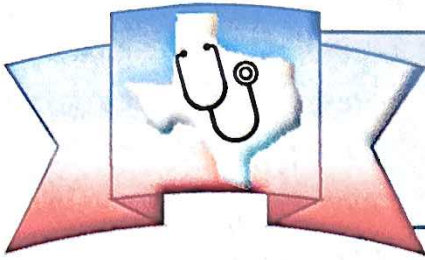
Please call: _____

If unable to reach me: _____ You may leave a detailed message.

_____ Please leave a message asking me to return your call.

PATIENT NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____



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MEDICAL RECORDS RELEASE
LIBERACION DE REGISTROS MEDICOS

If you have other doctors that have cared for you and have medical records of your treatment, this form enables us to obtain those records for Dr. Rodrigo DeLaCotera's review.

I hereby give my permission to release my medical records to :

Si usted tiene a otros médicos que han cuidado de usted y tienen los registros médicos de su tratamiento, esta forma nos permite obtener esos registros para la revisión del Dr. Rodrigo Delacotera

Yo por presente doy mi permiso de liberar mis registros médicos a:

DELACOTERA HEALTH CARE ASSOCIATION

DR RODRIGO DELACOTERA

129 Vision Park Pkwy, Suite 200

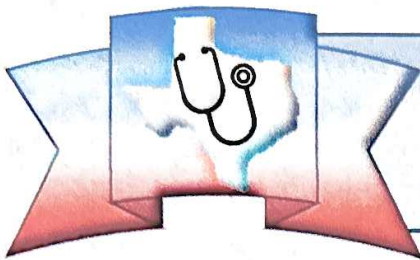
Shenandoah, TX 77384

Patient Name: _____

D.O.B: _____

Signature: _____

Date: _____



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INSURANCE LETTER EXPLANATION

Authorization to bill insurance

I, the undersigned hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at Delacotera Health Care. I therefore authorize the medical staff and personnel to release my medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bill not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, copayments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Patient Name: _____ D.O.B _____

Patient Signature



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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.

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Patient Signature: _____

DOB: _____

Patient Name: _____

DATE: _____

PATIENT NAME: _____ D.O.B: _____ HEIGHT: _____

MEDICATION LIST

Medication name	Dose	How Many Times a Day	Used For
Example: Metformin	500mg	Once a day	diabetes

PAST MEDICAL HISTORY (Please check all conditions that you have or have had)

NONE ANXIETY HIGH CHOESTEROL HEART DISEASE Hepatitis A B OR C
 STROKE SEIZURE HIGH BLOOD PRESSURE EDEMA DEPRESSION
 HIV HYPOTHYROID SLEEP APNEA OSTEOPOROSIS ARTHRITIS (TYPE) _____
 ASTHMA HYPERTHYROID DIABETES CORONARY ARTHERY DISEASE
 CANCER: TYPE/ TREATMENT: _____
 OTHER _____

PAST SURGICAL HISTORY: (Type of Surgery & Year): _____

DRUG ALLERGIES/ TYPE OF REACTION: _____

NO KNOWN/ DRUG ALLERGIES

SOCIAL HISTORY (Please check the appropriate listings)

ALCOHOL USE

NONE
 Socially
 Daily

TOBACCO USE

NEVER
 Quit/ When? _____
 Cigarettes/ Pack per Day? _____

DRUG USE

NONE
 Marijuana
 Amphetamines

FAMILY HISTORY

MOTHER: Living Deceased Medical History: NONE High Blood Pressure Diabetes Cholesterol

Cancer: Type: _____ Other: _____

FATHER: Living Deceased Medical History: NONE High Blood Pressure Diabetes Cholesterol

Cancer: Type: _____ Other: _____