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.

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	TOBACCO USE	DRUG USE
___NONE	___ NEVER	___ NONE
___Socially	___Quit/ When?_____	___Marijuana
___Daily	___ Cigarettes/ Pack per Day?_____	___ 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:_____