Patient Information

RGV FOOTCARE, P.A.
G. JAVIER CAVAZOS, D.P.M.

Last Name_____ First_____ MI_____

Street Address_____

City_____ State_____ Zip_____

Date of Birth _____ Gender [ ]Male [ ]Female SS#_____-_____-_____

Home Phone_____ Marital Status: [ ] Married – Spouse_____ [ ]Divorced [ ] Single

Occupation _____ Phone#_____ Ext_____

Height_____ Weight_____ Shoe Size_____

Reason for Today's visit:

Are you being referred over by another Physician? [ ] Yes [ ] No If so,

Name of Provider_____ Phone#_____ Last Visit_____

Who is your Family Care Physician? _____ Phone#_____

Do you currently have a pharmacy to fill prescriptions? [ ] Yes [ ]No

Name of Pharmacy_____ Location_____ Phone#_____

How did you hear of RGV FOOTCARE? [ ]Radio [ ]Newspaper [ ] Yellow Pages

[ ] Friend/Family Member [ ]Internet [ ] Other

I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor, administrator, and staff to perform such procedures as may be deemed necessary in the diagnosis and / or treatment of my feet.

I also grant RGV Footcare, P.A. permission to contact me about my Protected Health Information, Upcoming Appointments, and Financial Balances at the provided telephone number(s) and address.

If I choose to have restrictions on the disclosures of my Protected Health Information I will submit my request for the suggested restrictions in writing.

Signed _____ Date _____

Responsible party for the above patient_____

Relation _____ Date _____

RGV FOOTCARE, P.A.
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SIGNATURE ON FILE

Primary Insurance _____

Policy Number _____ Group Number_____

Secondary Insurance_____

Policy Number _____ Group Number_____

1. I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits.
2. I authorize use of this form on all my insurance submissions.
3. I authorize release of information to all my insurance companies.
4. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
5. I permit a copy of this authorization to be used in place of the original.
6. I authorize payment direct to my doctor.

7. I understand that if there has been no payment from my insurance carrier 45 days from my date of service I am financially responsible for payment of the services rendered to me as a patient of RGV FOOTCARE, P.A.
8. I understand that I may need to participate in the process of having my insurance claim expedited in order to have payment issued to the provider, if my insurance carrier takes longer than the expected time frame. (i.e. placing phone calls/setting up conference calls/ meeting with Insurance clerk)

Name_____(please print)

Signature_____ Date_____

Authorized Party _____ Relation_____ Date_____

RGV FOOTCARE, P.A.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding the attached Notice of Privacy Practices

This attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on your Authorization. In the following circumstances we may disclose your health information without your written authorization:

1. To family members/authorized member involved in your health care
2. For certain limited research purposes
3. For public health and safety
4. To government agencies for purposes of their audits, investigations, and other oversight activities
5. To government agencies to prevent child abuse, elderly abuse, or domestic violence
6. To the FDA to report product defects or incidents
7. To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
8. When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights. As our patient, you have the following rights:

1. You have access to and /or copy of your health information
2. To receive an accounting of certain disclosures we have made of your health information
3. To request restrictions as to how your information is disclosed; must be requested in writing
4. To request that we communicate with you in confidence
5. To request that we amend your health information
6. To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please ask to speak to the Privacy Officer in this office who may provide you with an address and telephone number to submit a formal complaint.

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the information provided to me. I understand that I may request a copy of this notice for my disclosure.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Patient Signature