New Patient Questionnaire

First Name: _____ Middle Name: _____

Last Name: _____ D.O.B: _____

Sex: ☐ Male ☐ Female Ethnicity: ☐ Hispanic or Latino ☐ South American Other _____

Race: ☐ White ☐ Afro American Other _____

Address: _____ City: _____

State: _____ Zip Code: _____

☐ House Phone ☐Cell phone: _____ Alternative phone: _____

Email: _____

Insurance: _____

Policy #: _____ Group #: _____

Guarantor's Name: _____ D.O.B: _____

Reason for Appointment: _____

Appointment Date & Time: _____

Apt. Reminder Method: ☐ Cell Phone ☐ Home Phone ☐Text Message (SMS) ☐E Mail

Mother's Name: _____ D.O.B: _____

Father's Name: _____ D.O.B: _____

Guardian Name: _____D.O.B:_____Relationship:_____

Dr. Olga Gomez Children's Clinic
Phone: (956)969-1313 Fax: (956)969-1322
910 E 8th Street suite 3 Weslaco,Tx 78596

Medical Release Form

Dear Dr. / Clinic _____ Phone: _____

Address _____

I hereby request that my medical records be released to Dr. Olga L Gomez M. D.

_____ Complete medical record & vaccines

_____ Records of care from _____ to _____ only.

_____ other, specify
_____

For the following patient

Name _____

D.O.B _____

The reason or the purpose of this release is

_____

_____

Signature _____ Date _____
(Patient or person legally authorized to consent on patient's behalf)

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Parental Preauthorization For Minors

I request and authorize Dr. Olga Gomez Children's Clinic and its personnel to deliver medical care to the child listed below:

Child Name _____ Date of Birth_____

_____
Parent's Signature

Acknowledgement of Review of Financial Policy

I have read and understand Dr. Olga Gomez Children's Clinic Financial Policy and understand that payment is due at the time services are rendered.

_____
Signature of Patient or Personal Representative

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Olga L. Gomez M.D., P.A.
Children's Clinic

Acknowledgement of Vaccines

I received or was offered a copy of the Vaccines Information Statement (VIS) for each vaccine. I know the risk of the disease each vaccine prevents. I know the benefits and risk of each vaccine. I have had a chance to ask questions about the disease, the vaccines, and how the vaccines are given. I know that the person receiving the vaccine will have the vaccine put into his / her body to prevent an infectious disease. I am an adult who can legally consent for the person named below to get the vaccine. I freely and voluntarily give my signed permission for the vaccines.

Privacy Notification: With few exceptions, you have the right to request and are informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined or incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notifications. (Reference: Government code, Section 552.021, 552.023, 559.003 and 559.004)

Privacy Notice: I acknowledge that I have received a copy of my immunization provider's HIPAA Privacy Notice.

Patient's Name: _____ Parent's Signature: _____

Date: _____

Reconocimiento de las Vacunas

Recibi o se me ofrecio una hoja con informacion sobre cada vacuna (VIS). Conozco los riesgos de las enfermedades que cada vacuna previene. Conozco los beneficios y riesgos que estas vacunas tienen. He tenido la oportunidad de hacer preguntas sobre las enfermedades, las vacunas y como son administradas las vacunas. Se que la persona reciviendo la vacuna la tendra en su cuerpo para prevenir una enfermedad contagiosa. Soy un adulto que puede dar su consentimiento legal para que la persona nombrada a continuación reciba la vacuna.

Notificacion Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la informacion que el Estado de Texas reune sobre usted. A usted se le debe conceder el derecho de recivir y revisar la informacion al requerirla. Usted tambien tiene el derecho de pedir que la agencia estatal corrija cualquier informacion que se ha determinado sea incorecta. Dirijase a http://www.dshs.state.tx.us para mas informacion sobre la Notificacion sobre privacidad. (Referencia: Government Code, Section 552.021,552.023,559.003 y 559.004)

Aviso Sobre Derecho de la Vida Privada: Reconozco que he recibido una copia del aviso de privacidad HIPAA de mi proveedor de vacunas.

Nombre Del Paciente: _____Firma Del Padre: _____

Fecha: _____

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Patient Financial Policy

We at Dr. Olga Gomez Children's Clinic are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

To assist us in establishing your Dr. Olga Gomez Children's Clinic financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and Dr. Olga Gomez with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification

Unaccompanied Minors: Minor must have an authorization letter for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/ or deductibles are expected at the time of service. For all services rendered to a minor patient, we look to the adult accompanying the patient and the parent or guardian with custody for payment.

Newborn Patients:
All newborn patients that are automatically covered under the mothers insurance have until they are 30 days old to present insurance information. If no insurance is presented at the end of 30 days the parent or legal guardian of the minor will be responsible for all acquired charges until that date.

Regarding Divorce:
Dr. Olga Gomez Children's Clinic does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantors below you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on the other parent.

Regarding Insurance:
We require full payment at the time of service. Any payment that your insurance requires such as deductibles, co-payments, co-insurance, etc. is due at the time of service. You must provide us with a current insurance cards and billing information at each visit. It is your responsibility to know your insurance policy, benefits and to be familiar with your coverage. This includes verifying whether or not providers are in/out of network with your specific policy. Please keep in mind that the contract is between you and your insurance company. We are not a party to your contract. If your insurance company does not pay for services rendered you will be responsible for the billed amount and any unpaid balances. We will bill your insurance as a courtesy and make every effort to ensure claims are submitted correctly and promptly.

- I have read and understand that I am personally responsible for payments on this account.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to pay any deductible, co-insurance, co-pay or services.
- Dr. Olga Gomez will bill my insurance and remaining balances will be sent to me in a statement

Guarantor Signature: _____ Date: _____

Guarantor Name: _____ Guarantor DOB: _____

Relationship to patient: _____Patient Name: _____

Patient DOB: _____

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