Joel A Rodriguez, MD

RioSurgical SPECIALISTS OF TEXAS

CONFIDENTIAL

Acct: **SSN#:** - -	**Phone ( ) Cell: ( )**
Last Name:	**Date of Birth: / / Age:**
First Name: Middle:	**Patient Employer:**
Address:	**Occupation:**
City	**Phone #: ( )**
State: Zip: County:	**[] Single [] Married [] Divorced [] Widowed**
Spouse:	**E-Mail:**
PCP: **Last Name First Name**	**Which Doctor Referred you?**
Phone #: ( )	**Preferred Language: □ English □ Spanish □ Other _____**
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Choose to not answer	**Race: □ American Indian or Alaska Native □ White □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ Choose to not answer**
Preference for Reminders: □ Email □ Mail □ Work Phone □ Home Phone □ Cell Phone □ Patient Portal □ Choose to not answer	

Primary Insurance:	**Secondary Insurance:**
ID#: Group#:	ID#: Group#:
Policy Holder:	**Policy Holder:**
Relationship: [] Self [] Spouse [] Child	**Relationship: [] Self [] Spouse [] Child**
Social Security#: DOB:	**Social Security#: DOB:**
Employer Name:	Employer Name:
Employer Telephone: ( )	Employer Telephone: ( )

IN CASE OF AN EMERGENCY CONTACT: **Name:**	**Name:**
Phone: ( ) Relation:	**Phone: ( ) Relation:**

AGREEMENTS OF BENEFITS:

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS, TO DR. RENE JASO. I UNDERSTAND THAT I AM RESPONSIBLE FOR FOLLOWING UP ON ANY DISCREPANCY IN COVERAGE WITH MY INSURANCE PLAN. I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE DR. RENE JASO TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

SIGNED:_____ **DATE:**_____

JOEL A RODRIGUEZ, MD

Please read each statement carefully & initial each that apply.

YOUR INITIAL INDICATES YOU AGREE WITH STATEMENT

Name: _____

___Have you ever seen Dr Joel Rodriguez before? Yes / No If yes; when & where were you last seen?

_____

____**Please be aware** that you are signing this notice in order to verify that all personal information as well as insurance information is valid & correct.

____In the event that the insurance presented is invalid, expired or if you have signed up for managed care plan (i.e., Medicare replacement programs: Secure Horizon, Humana Gold) without notifying the office of JOEL A RODRIGUEZ, M.D. **YOU WILL BE LIABLE FOR ALL NON-COVERED CHARGES.**

____**CO-PAYMENTS MUST BE PAID** to the front office **BEFORE** Dr. Rodriguez sees you. Please make checks payable to Joel A Rodriguez, M.D.

____ **Scheduling of surgical procedure (in office or in hospital).** Please be aware that once our office has confirmed a procedure or surgery date with you, the patient, you will be required to pay **$50.00** as a form of deposit. Should you cancel your procedure/surgery with **less than 1 weeks notice** there will be a **$50.00** cancellation fee charged to your credit card.

____**WE RESERVE THE RIGHT TO RESCHEDULE APPOINTMENTS** if the following items are not available: **CO-PAYMENT**

VALID & CURRENT INSURANCE CARDS & PROPER PICTURE IDENTIFICATION
PAYMENT FOR SERVICES RENDERED IF YOU DO NOT HAVE ACTIVE INSURANCE COVERAGE
PROPER REFERRAL AUTHORIZATION FROM YOUR PRIMARY CARE PHYSICIAN IF INDICATED

____If your insurance plan includes a **PRE-EXISTING CLAUSE;** you will be responsible for charges incurred for Dr. Rodriguez's services prior to service.

____If your insurance plan requires that you meet a **YEARLY DEDUCTIBLE;** the deductible amount must be paid to Dr. Joel Rodriguez **PRIOR** to surgery.

____It is the **PATIENT'S RESPONSIBILITY** to make sure that all laboratories, hospitals & any other facilities you are referred to are contracted with your insurance.

____After **THREE MISSED APPOINTMENTS,** we will dismiss you as a patient.

____Our office charges **$50.00 FOR ALL DISABILITY & OR FMLA FORMS** to be paid in advance**.** These forms will be filled out at the time of post-operative visit **NOT BEFORE;** we ask that the time frame to pick up is **7 WORKING DAYS.**

____If you have been involved in a personal injury accident & you are consulting with an attorney, payment is due at the time that services are rendered. Our office on a case-by-case basis if provided by your attorney can accept letter of protection.

____**WORKMAN'S COMPENSATION INJURIES** cannot be billed to your private insurance. If you have a work-related injury you must report it to your employer before being seen by our office unless it is an emergency. Our office needs the following information before you will be seen: claim number, date of injury and your employer's workplace address. You will be responsible for any denied charges if inaccurate information is given.

_____ _____

SIGNATURE **DATE**

PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), I have **certain rights to privacy regarding my protected health information.** I understand that **This information can and will be used to:**

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

You of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information have informed me. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address listed below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Person(s) who can receive my private information:

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to patient (if signed by personal representative of patient):

_____

RELEASE OF INFORMATION

Patient Name: _____ **DOB:** _____

Appointment Date:_____ **Surgeon: Joel A Rodriguez, M.D.**

Release of Information: I authorize the release of any medical information necessary to **Joel A Rodriguez, MD** to process this claim or provide medical information to any physician or medical facility.

Specific release for Mental health, drug or alcohol abuse or HIV information:

1) I hereby specifically authorize information that may include mental health, drug or alcohol abuse or HIV and related diseases, to release any and all information contained in my past or current medical records to the persons and organizations and for the purpose stated in Release of Information above.
2) By initialing the diagnosis (es)/condition(s) below, I do not consent to the release of such medical information, if any, to third party payors and understand I am personally responsible for payment.
   Mental Health_____ Drug and Alcohol Abuse_____ HIV_____

Disclosure is limited to:

□ No limitations placed on dates, history of illness, or diagnostic and therapeutic information.

□ Records regarding admission and treatment for the following medical condition or injury:
_____

□ Records for the period (dates) from _____ to _____

□ The following specified information:
_____

1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, except as provided in numbers 2 and 3 on this form.
2. If the purpose of this authorization is for an organization such as a health plan to Life Insurance Company to determine eligibility before enrollment, the requested use or disclosure is not for psychotherapy notes and I refuse to sign this authorization. The organization reserves the right to deny enrollment of eligibility for benefits.
3. If the purpose of this authorization is to disclose health information to another party based on healthcare that is provided solely to obtain such information, and I refuse to sign this authorization, **Joel A Rodriguez, MD** reserves the right to deny that healthcare.
4. I authorize that I may inspect or receive a copy of the information used or disclosed.
5. I understand that I may revoke this authorization at any time by notifying **Joel A Rodriguez, MD** in writing, except to the extent that:
6. Action has already been take in reliance of the authorization or
7. If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself

_____ _____

Signature of patient or patient's legal authorized representative Date

_____

Printed name of patient or patient's legal authorized representative

RioSurgical
SPECIALISTS OF TEXAS

DATE: _____

NAME: _____ DOB: _____

Have you been diagnosed with any of the following conditions? If yes, please give us the month and year you were diagnosed:

- ☐ Obesity ..... How Many Years: _____
- ☐ Non-insulin dependent Diabetes ..... Date Diagnosed_____
- ☐ Insulin dependent Diabetes ..... Date Diagnosed_____
- ☐ High Blood Pressure..... Date Diagnosed_____
- ☐ High Cholesterol..... Date Diagnosed_____
- ☐ Sleep Apnea..... Date Diagnosed_____
- ☐ Heartburn..... Date Diagnosed_____
- ☐ Gall Stones..... Date Diagnosed_____
- ☐ Coronary Artery Disease..... Date Diagnosed_____
- ☐ Congestive Heart Failure..... Date Diagnosed_____
- ☐ Chronic Pulmonary Heart Disease..... Date Diagnosed_____
- ☐ Stress Urinary Incontinence..... Date Diagnosed_____
- ☐ Degenerative Joint Disease..... Date Diagnosed_____
- ☐ Osteoarthritis..... Date Diagnosed_____
- ☐ Back Pain..... Date Diagnosed_____
- ☐ Asthma..... Date Diagnosed_____
- ☐ Depression..... Date Diagnosed_____
- ☐ Thyroid Disease..... Date Diagnosed_____
- ☐ Pulmonary Disease/Chronic Obstructive Pulmonary Disease ..... Date Diagnosed_____
- ☐ Other: _____..... Date Diagnosed_____
- ☐ Other: _____..... Date Diagnosed_____
- ☐ Other: _____..... Date Diagnosed_____
- ☐ Other: _____..... Date Diagnosed_____

Pharmacy:_____ **Pharmacy Phone:** _____

Pharmacy address or cross streets: _____

NAME: _____ DOB: _____

***Surgical History:**

- ☐ Tonsillectomy……..Surgery Date: _____
- ☐ Cholecystectomy/Gall Bladder…….. Surgery Date: _____
- ☐ Appendectomy…… Surgery Date: _____
- ☐ Hysterectomy……. Surgery Date: _____
- ☐ Oopherectomy: ……Surgery Date:_____
- ☐ C-section: ……Surgery Date:_____
- ☐ Bilateral Tubal Ligation……. Surgery Date: _____
- ☐ Bowel Surgery: ……. Surgery Date: _____
- ☐ Hernia Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____
- ☐ Other Surgery: Type: _____ Surgery Date: _____

Current Medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Medication Allergies:

1. _____
2. _____
3. _____