PHYSICIANS OF KATY

462 S. Mason Road, Suite 100
Katy, TX 77450
Phone 281.693.5289 * Fax 281.693.3111

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH (mm/dd/yyyy)	SOCIAL SECURITY NUMBER	SEX (circle one) MALE / FEMALE / TRANSGENDER

MARITAL STATUS (circle one) MARRIED / SINGLE / OTHER	SPOUSE NAME	SPOUSE PHONE NUMBER

MAILING ADDRESS		

CITY	STATE	ZIP

STREET ADDRESS (if different from above)		

CITY	STATE	ZIP

HOME PHONE	CELL PHONE	WORK PHONE

EMPLOYER NAME	EMPLOYER ADDRESS (Street Address, City, State, Zip)

REASON FOR TODAY'S VISIT

RESPONSIBLE PARTY

IF DIFFERENT FROM PATIENT INFORMATION ABOVE

NAME (First, Middle, Last)	RELATIONSHIP TO PATIENT (circle one) SPOUSE CHILD OTHER _____

MAILING ADDRESS		

CITY	STATE	ZIP

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		

POLICY HOLDER NAME	DATE OF BIRTH (mm/dd/yyyy)	SEX (circle one) MALE / FEMALE / TRANSGENDER

POLICY NUMBER	GROUP NUMBER

CLAIMS ADDRESS	CITY	STATE	ZIP

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY		

POLICY HOLDER NAME	DATE OF BIRTH (mm/dd/yyyy)	SEX (circle one) MALE / FEMALE / TRANSGENDER

POLICY NUMBER	GROUP NUMBER

CLAIMS ADDRESS	CITY	STATE	ZIP

ACKNOWLEDGEMENT & SIGNATURE

I HEREBY ACKNOWLEDGE AND CONFIRM, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I hereby authorize Hector Ubaldo M.D., P.A. to furnish my insurance company(ies) and other physicians any medical information acquired in the course of my examination or treatment.
ASSIGNMENT OB BENEFITS: I hereby authorize payment directly to Hector Ubaldo M.D., P.A. of all benefits due for services provided. All payments are due at the time of service.

PATIENT SIGNATURE	DATE (mm/dd/yyyy)
GUARDIAN SIGNATURE *** Patients under the age of 18 MUST be accompanied by parent or guardian ***	DATE (mm/dd/yyyy)

CONTACT AUTHORIZATION

I, _____, hereby give Physicians of Katy permission to leave messages regarding NORMAL lab results, scheduled appointments, calls to my pharmacy regarding medications or refills, or general call back information on my voicemail at the following phone numbers:

☐ HOME ( ) -

☐ CELL ( ) -

☐ OFFICE ( ) -

I also give permission for Physicians of Katy to contact me via Text Message on my cell phone at:

CELL ( ) -

***Please note, Physicians of Katy **does NOT charge** for this service**, but standard text messaging rates MAY apply as provided in your wireless plan** (contact your carrier for pricing plans and details).*

You may opt out of the text message service at any time by calling Physicians of Katy. We will unsubscribe you from our text messaging service immediately.

I also give permission for Physicians of Katy to contact me via my email address at:

EMAIL: _____@_____

PREFERRED LANGUAGE: ☐ English OR ☐ Spanish

_____ _____
Printed Patient Name DOB

_____ _____
Patient Signature Date

_____ _____
Legal Guardian/Responsible Party Signature Date

_____ _____
Legal Guardian/Responsible Party Printed Name Relationship to Patient

PHYSICANS OF KATY

POLICY AUTHORIZATION

PATIENT NAME _____ DOB _____DATE _____

Please read and initial **EACH NUMBER FROM 1-7**

____ **1. Consent for treatment:** Knowing that I suffer from conditions requiring diagnostic, medical, or surgical treatment, do hereby voluntarily consent to such procedures and care under Dr. Ubaldo, his assistant, and his designee as necessary by their judgment. I acknowledge that there are no guarantees made to me as a result of treatment or examination.

____ **2. Release of Medical Information:** I hereby authorize Physicians of Katy to release any medical information regarding the services performed to my insurance company, WC, or any other physicians for continuation of care, and determination of payable benefits. A written notice is needed to stop release of medical records.

____ **3. Assignment and Release of Insurance Benefits:** I hereby assign all benefits due me by named insurance company and any third party payer to be paid directly to Hector Ubaldo M.D., P.A. **I understand that I am financially responsible for all charges whether or not paid by my insurance**.

____**4. Medicare ONLY:** I authorize Medicare benefits to be made on my behalf to Hector Ubaldo M.D. P.A. for any services furnished to me by the Doctor. I authorize all medical information about me to be release to the Health Care Administration and its agent any information needed to determine benefits payable to related services.

I understand my initials request that payment be made and authorizes release of medical information necessary to pay claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductable, co-insurance, and non-covered service(s). Co-insurance and the deductible are based upon the charge determination to the Medicare carrier.

____ **5. HIPAA notice:** We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance Officer in person or by phone at (281) 693-5289.

____ **6. Financial Policy: $25.00 FEE will be assessed on all NO Show** appointments. This includes but not limited to office visit, well woman exams, school/work physicals, stress test, and physical therapy. **Patients share of Co-pays, Deductibles, and Co-insurances are due at time of service.** If requested, a copy of services provided will be given to you. Physicians of Katy will file your office charges with most health plans. Non-participating carriers will not be filed and a copy of your office charges will be given to you to submit to your insurance carrier. Statements are mailed out monthly. If no payment is received within the 3rd statement (90-120 days), your account will be deferred to collections.

____**7**. A **current insurance card must be present** at time of appointment for all new patients and all establish patients doing a change of insurance. If it's not present, patient will pay self paid prices, and have up to 24 hours to supply insurance card for reimbursement pending insurance benefit verification. **THEY WILL BE NO REINBURSMENT OF SELF PAID PRICES AFTER 24 HOURS.**

*******If you have questions, concerns, or difficulty with making payments, please request to speak to our Billing Representative***

PHYSICIANS OF KATY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____, hereby request and authorize the release of following information to the specified person(s) listed below: (check all that apply)

☐ All healthcare information

☐ Healthcare information regarding labs and diagnostic test results

☐ STD results, HIV/AIDS testing, whether negative or positive

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et esq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Any records regarding drug, alcohol, or mental health treatment

☐ Other *Please specify* _____

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

If you wish to change, add or remove the information disclosed or the person(s) listed above, please notify Physicians of Katy immediately.

_____ _____

Patient Signature Date

_____ _____

Printed Name DOB

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****PLEASE KEEP THIS SHEET FOR FUTURE REFERENCE****

WELCOME TO PHYSICIANS OF KATY
Hector Ubaldo M.D., P.A..

We are pleased that you have chosen Physicians of Katy to provide your health care and we are committed to patient service. The following information is intended to assist you in successfully managing your health care needs.

APPOINTMENT TIPS:
Please call our office at the number listed above so that we can schedule a visit appropriate to your needs. It is necessary that your doctor knows about ALL the medicines you are taking. It is also helpful if you bring a problem list with you.

"WORK-IN" APPOINTMENTS:
If you require an unscheduled or "work-in" appointment, you will be seen by the available physician, nurse practitioner or physician's assistant as soon as possible. However, please understand that you may have to wait for an extended period of time as there are usually other scheduled patients waiting also. If you do not feel well enough to sit in the waiting room, please tell the receptionist.

LATE ARRIVALS AND CANCELLATIONS:
If you arrive late for an appointment, you may have to be rescheduled. If you cannot keep an appointment, please be considerate and call to cancel your appointment. The following fees will apply for **no-show** appointments:

$25.00 fee assessed on all cancellations made within 24 hrs of the scheduled office visit for the following: Office Visit, Well Woman Exam, School/Work Physical, Complete Physical

$25.00 fee assessed on all cancellations made within 48 hrs of the scheduled office visit for the following: Stress Test, Physical Therapy Holter, VNG, EMG, Ultrasound

TELEPHONE CALLS:
Our nurses make every effort to return phone calls the same day they are received. If your call has not been returned within 24 hrs, please call again. If you have an emergency, please make this clear to the receptionist and the nurse will be paged.

INSURANCE:
Physicians of Katy participates with most insurance products available in this area, although there are several different plans under each insurance company's umbrella of products. It is your responsibility to confirm with your insurance company whether your particular plan is covered at Physicians of Katy. Additionally, when we refer you to another physician or diagnostic facility, we will make every attempt to choose one that accepts your insurance plan, but it is your ultimate responsibility to confirm whether your particular plan is covered by these facilities.

PRESCRIPTION REFILLS:
Routine prescriptions will be refilled through your pharmacy. Call your prescription number to your pharmacist who will then call our office. **Please allow 48 hours for us to refill prescriptions.** If you urgently need a refill, please notify your pharmacist.

Prescriptions for pain and sleep will only be refilled by your doctor. <u>These medications will not be refilled after hours or on weekends.</u> If you have questions about a medication, please call our office and leave a message for the nurse.

LAB RESULTS:
After you have blood drawn, the results will be reviewed by your doctor. If the results require urgent attention, you will be notified by telephone immediately. **If the results are normal, you usually will be notified within 2-3 weeks.** Please do not call the office for lab results before that time.

GENERAL GUIDELINES FOR HEALTH MAINTENANCE

1 We uniformly advise a "no smoking" policy for all our patients. At your request, we will be glad to advise you on smoking cessation aids and programs available.
2 If alcohol is consumed, it should be limited to 2 ounces or 2 beers per day.
3 Regular exercise has tremendous health benefits – an aerobic activity (including brisk walking) for 30 minutes at least 3 to 4 times per week is advisable unless contraindicated by other medical conditions.
4 A low-fat, low-cholesterol, relatively low-sugar diet is suggested for all patients. Excess fats and sugar contribute to many health problems.
5 Excessive sun exposure is a major risk factor. We recommend sun screens and occlusive hats and clothing as well as sun avoidance during peak sun exposure hours.
6 We strongly recommend seat belt use as it has been shown to reduce the risk of serious injury.
7 Yearly flu shots are suggested for all patients and strongly recommended for those age 65 or older (earlier if chronic illnesses) but are not recommended for those allergic to eggs.
8 Tetanus boosters are recommended every 10 years.

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Physicians of Katy is committed to protecting the health information that we maintain about you. As required by rules effective April 14,2003, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this notice provides you with information about your rights and our legal duties and practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures that Physicians of Katy will make of your protected health information.

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your past, present or future health care and treatment or the payment for your health care and treatment. Your health care professional may have different policies or notices regarding his or her use and disclosure of your health information created in the health care professional's office or clinic.

Physicians of Katy reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a paper copy of the most current privacy notice from our office.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION The following describes the purposes for which Physicians of Katy is permitted or required by law to use or disclose your Health Plan coverage information without your authorization:

TREATMENT This means the provision, coordination or management of your health care, including any referrals for health care from one health professional to another. For example, we may use or disclose health information about you to facilitate treatment or services by health care providers. We may disclose health information about you to other health care professionals who are involved in taking care of you.

PAYMENT This means activities to facilitate payment for the treatment and services you receive from health care professionals, including to determine eligibility, coverage or benefit responsibilities under your insurance coverage, or to coordinate your insurance coverage. For example, the information on claim forms sent to us may include information that identifies you, ﷺ well ﷺ your diagnosis, and the procedures and supplies used. We may share this information with outside health care consultants performing a business service for Physicians of Katy.

HEALTH CARE OPERATIONS This means the support functions related to treatment and payment, such as quality assurance activities, case management, underwriting, premium rating, business management and other general administrative activities. For example, we may use health information in connection with conducting quality assessment and improvement activities, underwriting, premium rating and other activities relating to your coverage. We may also disclose health information to business associates if they need to receive health information to provide a service to us and by contract agree to abide by the same high standards of safeguarding your health information.

AS REQUIRED BY LAW OR FOR PUBLIC HEALTH ACTIVITIES. We will disclose health information about you when required to do so by federal, state or local law. For example, we may disclose health information when required by a court order, subpoena, warrant, summons or similar process. We may disclose health information to public health or legal authorities charged with preventing or controlling communicable disease or to a governmental agency or regulator with health care oversight responsibilities.

MILITARY AND VETERANS If you are a member of the armed forces, we may disclose health information about you as required by military command authorities.

CORONERS AND MEDICAL EXAMINERS We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

LAWSUITS AND DISPUTES If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

LAW ENFORCEMENT AND NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES We may disclose health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY We may disclose health information to avert a serious threat to someone's health or safety. We may disclose health information to federal, state or local agencies engaged in disaster relief to allow such entities to carry out their responsibilities in specific disaster situations.

OTHER USES AND DISCLOSURES OF YOUR HEALTH INFORMATION Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization.

YOU'RE RIGHTS REGARDING YOUR HEALTH IN FORMATION The following describes your rights regarding the health information we maintain about you. To exercise your rights, you must submit your request in writing to Physicians of Katy 462 S. Mason Rd, Suite 100 Katy, Texas 77450

RIGHT TO INSPECT AND COPY You have the right to inspect and copy health information that we maintain about you. To inspect or copy your health information, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Please contact our Privacy Contact at the address or telephone number listed on the last page of this document if you have questions about access to your health information.

RIGHT TO AMEND If you feel that the health information we have about you is incorrect or incomplete; you may ask us in writing to amend the information. You have the right to request an amendment for as long as we maintain the information.

In addition, you must provide a reason that supports your request. Any agreed-upon correction to your health information will be included as an addition to, and not a replacement of, already existing records.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the health information kept by us, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy or (4) is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES You have the right to request an accounting of disclosures of your health information made by us in the six years prior to the date that the accounting is requested (or shorter period as requested). This does not include disclosures (1) to carry out treatment, payment, or health care operations; (2) made to you or pursuant to your authorization; (3) for national security or intelligence purposes; (4) to corrections institutions or law enforcement officials or (5) made prior to April 14, 2003. Your first request for an accounting in any 12-month period shall be provided without charge. A reasonable fee shall be imposed for each subsequent request for an accounting within the same12-month period.

RIGHT TO REQUEST RESTRICTIONS You have the right to request a restriction or limitation of the health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request.

To request restrictions, you must make your request in writing to our Privacy Contact indicated below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both and **(3)** to whom you want the limits to apply.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We will not ask you the reason for your request. Please make this request in writing to our Privacy Contact indicated below.

YOU'RE RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, please submit your complaint in writing to: Physicians of Katy 462 S. Mason Rd, Suite 100 Katy, Texas 77450

You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

PRIVACY CONTACT If you have any questions or would like further information about this notice or your rights regarding your health information, please our office at 462 S. Mason Rd, Suite 100 Katy, TX 77450, Phone (281) 6935289.

This notice is revised effective September 6, 2011.