RGV HEALTH
MEDICAL CLINIC, PLLC

REGISTRATION FORM

(Please fill in and check the boxes ☑ that apply)

Today's Date (mm/dd/yy)

_____/_____/_____

PATIENT INFORMATION

Last Name

Birth Date (mm/dd/yy)

_____/_____/_____

Sex

☐ Female

☐ Male

Marital Status

☐ Single ☐ Married

☐ Divorced ☐ Widow

First Name (and middle name if applicable)

Social Security Number

_____ - _____ - _____

Race (select one)

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Multiracial

Ethnicity (select one)

☐ Hispanic

☐ Non-Hispanic

Primary Language

☐ English

☐ Spanish

☐ Other: _____

Street Address

City

State

ZIP Code

Phone

(_____) _____ - _____

Email

INSURANCE INFORMATION

Primary Insurance

☐ Medicare ☐ Medicaid ☐ Wellmed ☐ BCBS of TX ☐ Ambetter ☐ Humana ☐ Imagine Health ☐ Cigna

☐ Wellcare ☐ Aetna ☐ Molina ☐ Superior ☐ HealthSpring ☐ United Healthcare ☐ Other: _____

Group Number

Policy Number

Co-Payment

$ _____

Secondary Insurance (if applicable)

☐ Medicare ☐ Medicaid ☐ Wellmed ☐ BCBS of TX ☐ Ambetter ☐ Humana ☐ Imagine Health ☐ Cigna

☐ Wellcare ☐ Aetna ☐ Molina ☐ Superior ☐ HealthSpring ☐ United Healthcare ☐ Other: _____

Secondary Insurance Group Number (if applicable)

Secondary Insurance Policy Number (if applicable)

Co-Payment

$ _____

If the patient is not the insurance subscriber, please provide the subscriber's information below. If the patient is the subscriber, skip this section.

Subscriber's Last Name

Subscriber's Birth Date (mm/dd/yy)

_____/_____/_____

Patient's Relationship to Subscriber

☐ Spouse

☐ Child

☐ Other: _____

Subscriber's First Name (and middle name if applicable)

Subscriber's Social Security Number

_____ - _____ - _____

EMERGENCY CONTACT

Name of local friend or relative in case of an emergency

Relationship to Patient

Phone

(_____) _____ - _____

REFERRAL

How did you hear about this clinic?

☐ Insurance plan ☐ Internet search ☐ Social media ☐ Family ☐ Friend ☐ Outside sign ☐ Flyer ☐ Other: _____

RELEASE OF MEDICAL INFORMATION CONSENT

☐ I do not wish to give permission to release information regarding my health or results of any kind to anyone other than myself or my legal personal representative.

☐ I give permission to RGV Health Medical Clinic, PLLC to release to the person(s) listed below my medical information regarding appointments, diagnostic test results, etc. The only exceptions to this permission are the results pertaining to sexually transmitted diseases or HIV, as these require my additional consent.

Name(s): _____ Relation to patient: _____

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HEALTH INFORMATION

(Please fill in and check the boxes ☑ that apply)

FAMILY HEALTH HISTORY

	Self	Father	Mother		Self	Father	Mother
Heart Disease	☐	☐	☐	**Asthma**	☐	☐	☐
High Blood Pressure	☐	☐	☐	**Rheumatoid Arthritis**	☐	☐	☐
Stroke	☐	☐	☐	**Gout**	☐	☐	☐
Cancer	☐	☐	☐	**High Cholesterol**	☐	☐	☐
Diabetes	☐	☐	☐	**COPD**	☐	☐	☐
Allergies	☐	☐	☐	**Depression**	☐	☐	☐
Other (please specify)	_____	_____	_____	**Other** (please specify)	_____	_____	_____

WOMEN ONLY

Are you pregnant or breastfeeding? ☐ Yes ☐ No | **Number of pregnancies:** _____ | **Number of live births:** _____

If you are 40 years or older, have you had a mammogram done? ☐ Yes ☐ No

If yes, what year was the test done: _____ ☐ Result normal ☐ Result abnormal, please specify: _____

Have you had a Pap smear done? ☐ Yes ☐ No

If yes, what year was the test done: _____ ☐ Result normal ☐ Result abnormal, please specify: _____

HEALTH HABITS AND PERSONAL SAFETY

Do you exercise?

☐ No
☐ Once or twice a week
☐ More than twice a week

Do you consume alcohol?

☐ No
☐ One or two drinks/beers a week
☐ More than two drinks/beers a week

Do you consume street drugs?

☐ No
☐ Occasionally
☐ Once a week or more

Do you smoke tobacco?

☐ No, never have
☐ Not currently, but I used to smoke for about _____ years the equivalent to _____ packs per day
☐ Yes, I have been smoking for about _____ years the equivalent to _____ packs per day

Have you had any falls within the last year?

☐ No
☐ Yes, how many? _____

If you are 45 years or older, have you had a colonoscopy done? ☐ Yes ☐ No

If yes, what year was the test done: _____ ☐ Result normal ☐ Result abnormal, please specify: _____

Do you have advance directives? ☐ Yes ☐ No

Advance directives are legal documents that allow you to spell out your decisions about end-of-life care ahead of time. A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions for you if you are unable to do so. It may include the following:

- whether to accept or refuse medical care if dying or permanently unconscious
- the use of dialysis and breathing machines
- a statement on whether you want to be resuscitated
- what to do if your breathing or heartbeat stops
- whether to accept tube feeding
- your willingness to donate organs or tissue

PHARMACY

Pharmacy Name and Location

List below all prescribed and over-the-counter drugs you take regularly, including vitamins and inhalers. If you need additional space, please use the back of this page.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List below allergies to medications with the names and reactions you had.

1. _____ 2. _____

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OFFICE POLICIES

AUTHORIZATION TO TREAT

By signing below, I give full authorization to Dr. Rafael Otero and his staff to treat my medical conditions and illnesses.

MEDICATION ACKNOWLEDGMENT

I consent to all laboratory exams and office procedures my medical provider may consider necessary for my treatment. I also agree to read all package inserts of any medication prescribed to me and ask all the questions before taking such medications. If any samples are provided to me, I further agree to ask for the package inserts of the samples to read them and ask all the questions before taking the samples. I also agree to comply with the medical recommendations and follow up appointments given to me. Failure to do so may seriously affect my health and my life. I also agree if I miss two appointments on a consecutive basis, I may be dismissed from the practice for failure to follow up.

PAYMENT POLICIES

Our office verifies all insurances prior to your first appointment. The information obtained from your insurance carrier is not a guarantee of payment. It is only a review of the patient's benefits.

I authorize payments to be made directly to RGV Health Medical Clinic, PLLC or Rafael Otero, MD for the medical benefits, if any, otherwise payable to me for their services, realizing that I am responsible to pay non-covered services and co-payments as required by my insurance. I understand that my co-pay / co-insurance / deductible must be collected before services are rendered.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments. Our office accepts cash, check, debit card, Visa, and MasterCard. There is a service charge of $25.00 for returned checks. Co-payments are collected at the time of registration. If a patient is unable to pay the copayment, we will need to reschedule the appointment.

Patients with pending deductibles or without insurance will be required to pay $120.00 for the first time visit and $100.00 for each follow-up visit. Payment must be made at check in. Patient credits will be applied to the next visit or refunded if no other appointment is necessary.

Patients with an outstanding balance need to communicate with our billing and collection staff so that they may assist you to create a financial plan. After the second attempt to collect payment, your account will be reported to a collection agency.

MEDICARE SUPPLEMENTAL INSURANCE

We are a participating provider with the Medicare Part B program. As such, we are obligated to write off the difference between what Medicare pays us for the services rendered to you (the "allowed amount") and our usual and customary charge. Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% co-pay and your annual deductible are the patient's responsibility by federal law.

TRAVELERS INSURANCE FOR INTERNATIONAL PATIENTS

Any international patient who has Canadian or any other foreign health care insurance or traveler's insurance, automatically become self-pay patients. It is the patient's responsibility to file their claim with the insurance company.

REFILL OF MEDICATIONS

Medications must be refilled during your doctor's visit. If you call to request a refill of medications, allow us up to 3 business days to process your request. No refills will be authorized if the patient has not been seen by the doctor for more than 3 months or the time recommended by the doctor. I have been advised, understand, and agree that RGV Health Medical Clinic has the right to do a medication history check from the pharmacies.

MEDICAL RECORDS REQUEST

Patients requesting copies of their medical records must first sign a release form. The charge is $1.00 per page for the first 25 pages and $0.50 cents for each additional page thereafter. Records can be picked up with a photo ID. They cannot be mailed. This is to ensure patient confidentiality.

NO-SHOW TO AN APPOINTMENT

Patients failing to cancel or reschedule an appointment with at least 24-hour notice will be subject to a $25.00 failed appointment fee.

RELEASE OF MEDICAL RECORDS

I hereby also authorize my primary care provider to release any information acquired in the course of my treatment necessary to process insurance claims and to any consulting physician I may be referred to. If my insurance is an HMO or PPO, it is my responsibility to ensure my doctor is listed as my primary care physician.

FMLA CERTIFICATION FORMS

The following certification forms by the healthcare provider for a serious health condition (Family and Medical Leave Act, FMLA) requested by the patient have a cost of $35, payable at the time of completion by the doctor. These forms may take up to 10-14 business days to be processed.

- Form WH-380-E (employee's serious health condition) - use when a leave request is due to the medical condition of the employee.
- Form WH-380-F (family member's serious health condition) - use when a leave request is due to the medical condition of the employee's family member.

AGREEMENT

I certify that all the information I provided is true and correct to the best of my knowledge. I will notify Dr. Rafael Otero and his staff of any changes in the status of the above information. I permit a copy of this authorization to be used in place of the original. The authorization is in force until it is either canceled or changed by me and so noted in writing.

By signing below, I agree that I have carefully read the above statements and agree with all provisions and authorizations set forth in said statements.

Patient signature: _____ **Date (mm/dd/yy): _____/_____/_____**

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(Please fill in and check the boxes ☑ that apply)

Patient's Name	**Birth Date** (mm/dd/yy)
_____	_____/_____/_____
Previous/Maiden Name (if applicable)	**Social Security Number**
_____	_____ - _____ - _____

I request and authorize the following healthcare providers to release my healthcare information to:

RGV Health Medical Clinic, PLLC
832 Ridgewood St. Suite B, Brownsville, Texas 78520
Phone: (956) 667-5298
Fax: (888) 498-3755

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

This request and authorization apply to the following:

☐ Last consult	☐ Last colonoscopy and FOBT	☐ _____
☐ Last labs	☐ Last mammogram	☐ _____
☐ Last radiology report	☐ Last Pap smear	☐ _____

Patient signature: _____ Date (mm/dd/yy): _____/_____/_____