Patient Information

First Name	MI.	Last Name	Date of Birth
Address	City	State	Zip Code
Please check Primary phone	□ Home phone	□ Work phone	□ Cell phone
Other Name(s) Used		E-mail Address-	

Gender □ M □ F	Social Security #	Preferred Language	Driver's License
Martial Status □ Married □ Single □ Divorced □ Separated □ Widowed □ Life Partner	Preferred Contact □ Mail □ Home Phone □ Day Phone □ Cell Phone □ Patient Portal (My Chart)	Ethnicity □ Hispanic/Latino □ Non-Hispanic □ Filipino	Race □ Asian □ Black □ Hispanic/White □ White □ Other/Multi

Primary Care Provider	Referring Provider

Responsible Party (Guarantor) □ **Same as patient**

First Name	MI	Last Name	Date of Birth
Address	City	State	Zip Code
Please check Primary Phone	Home Phone □	Work Phone □	Cell Phone □
SSN	Relationship to Patient	Preferred Language	Driver's License

Emergency Contact (for minor child, this section may be used for parent)

First Name	MI	Last Name	Date of Birth
Address	City	State	Zip
Please check Primary Phone	□ Home phone	□ Work phone	□ Cell phone

I/We understand that I WILL BE RESPONSIBLE for payment of all charges incurred. I will also be responsible for any Referrals or Authorizations. We request that all office visits be paid at the time of service. We look to you for payment of any services rendered. We do not hold Secondary Insurances Responsible for payment.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Print)	Relationship to Patient

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advanced Directives

□ None □ Do Not Resuscitate □ Power of Attorney □ Living Will □ Advance Directive

Medications- Bring all medications/vitamins to every office visit.

□ I do not take any medications

Medication and Food Allergies- List all known allergies (drugs, food, animals, etc.)

□ No known Allergies

Medical History- Check if you have ever experienced the following conditions, and year of onset.

Condition	Year	Condition	Year
□ None		□ Gallbladder Disease	
□ Allergies		□ GERD (Reflux)	
□ Anemia		□ Hepatitis C	
□ Angina		□ Hyperlipidemia	
□ Anxiety		□ Hypertension	
Condition	Year	Condition	Year
□ Arthritis		□ Irritable Bowel Disease	
□ Asthma		□ Liver Disease	
□ Atrial Fibrillation		□ Migraine Headaches	
□ Benign Prostatic Hypertrophy		□ Myocardial Infarction	
□ Blood Clots		□ Osteoarthritis	
□ Cancer- Type		□ Osteoporosis	

□ Cerebrovascular Accident		□ Peptic Ulcer Disease	
□ Coronary Artery Disease		□ Renal Disease	
□ COPD (Emphysema)		□ Seizure Disorder	
□ Crohn's Disease		□ Thyroid Disease	
□ Depression		□ Other	
□ Diabetes		□ Other	
Surgical History- Check if you have received the following procedures, and year performed.			
Surgical Procedure	Year	Surgical Procedure	Year
□ None		(Male Only)	
□ Angioplasty		□ Prostate Biospy	
□ Angioplasty w/ Stent		□ TURP (Trans-urethal resection of Prostate)	
□ Appendectomy		□ Vasectomy	
□ Arthroscopy Knee		□ Other	
□ Back Surgery		□ Other	
□ CABG (heart bypass)			
□ Carpal Tunnel Release		(Female Only)	
□ Cataract Extraction		□ Augmentation Mammoplasty	
□ Cholecystectomy		□ Bilateral Tubal Ligation	
□ Colectomy		□ Breast Biospy	
□ Colostomy		□ Cesarean Section	
□ Gastric Bypass		□ D and C	
□ Hernia Repair		□ Hysterectomy	
□ Hip Replacement		□ Mastectomy	
□ Knee Replacement		□ Myopmectomy	
□ LASIK		□ Reduction Mammoplasty	
□ Liver Biospy		□ TAH/BSO	
□ Pacemaker		□ Vaginal Hysterectomy	
□ Small Bowl Resection		□ Other	
□ Thyroidectomy		□ Other	
□ Tonsillectomy			
Health Maintenance- Check if you have received the following, and date of most recent exam.			

Exam	Date	Exam	Date
□ None		□ GYN Exam	
□ Breast Exam		□ Influenza Vaccine	
□ Cardiac Stress Test		□ Lipid Panel	
□ Colonoscopy		□ Mammogram	
□ DEXA Scan		□ PAP Test	
□ Echocardiogram		□ Physical Exam	
□ EKG		□ Pneumoccal Vaccine	
□ Eye Exam		□ Pulmonary Function Test	
□ FOBT (stool card for hidden blood)		□ Sigmoidoscopy	
□ Foot Exam		□ Tetanus Vaccine	

Family History- Check if any family member(s) has had any of the following conditions.

□ Adopted

Diagnosis	Mother	Father	Brother	Sister	Other
Alcoholism	□	□	□	□	□
Allergies	□	□	□	□	□
Alzheimer's Disease	□	□	□	□	□
Asthma	□	□	□	□	□
Blood Disease	□	□	□	□	□
CAD (Heart Attack)	□	□	□	□	□
Cancer- Type:	□	□	□	□	□
CVA (Stroke)	□	□	□	□	□
Depression	□	□	□	□	□
Developmental Delay	□	□	□	□	□
Diabetes	□	□	□	□	□

Family History- continued

Diagnosis	Mother	Father	Brother	Sister	Other
Eczema	□	□	□	□	□
Hearing Deficiency	□	□	□	□	□
Hyperlipidemia (LDL)	□	□	□	□	□
Hypertension (High BP)	□	□	□	□	□
Irritable Bowel Disease	□	□	□	□	□
Learning Disability	□	□	□	□	□

Mental Illness	□	□	□	□	□
Tuberculosis	□	□	□	□	□
Obesity	□	□	□	□	□
Osteoarthritis	□	□	□	□	□
Osteoporosis	□	□	□	□	□
PVD	□	□	□	□	□
Renal Disease	□	□	□	□	□
Other	□	□	□	□	□

Social History for Adult Patient

Occupation		Employer	
Do you have children? □ YES □ NO		How many?	Female(s) / Male(s)
Tobacco Use □ NO	□ Daily □ Weekly □ Less □ Former/Yr Quit:	□ Chewing □ Pipe □ Cigar □ Cigarette □ Smokeless Brand:	
Alcohol Use □ NO	□ Daily □ Weekly □ Less □ Former/Yr Quit:	□ Beer □ Wine □ Liquor □ Other	
Excercise Activity	□ Moderate □ Vigorous □ Sedentary Days/Week:	Sleep Pattern □ Changes □ No Changes	
Caffine Use □ NO	□ Daily □ Weekly □ Less □ Former/Yr Quit:	□ Chocolate □ Coffee □ Soda □ Tea □ Tablets □ Other	

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ACKNOWLEDGMENT OF RECEIPT

Joint Notice of Privacy Practices

Your name and signature on this form indicates that you have read the Valley Medicine Associate's Joint Notice of Privacy Practices.

If you have any questions regarding the information contained in **Valley Medicine Associate's Joint Notice of Privacy Practices,** please contact Valley Medicine Associate's Chief Compliance Officer at (956) 440-2800.

Printed Name: _____

Signature: _____

Relationship to Patient: _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgment of patient's receipt of our Joint Notice of Privacy Practices, but acknowledgment could not be obtained from the patient for the following reason:

□ Individual Refused to Sign
□ Emergency Situation Prevented Signature
□ Patient Requested Above Individual Sign on His/Her Behalf
□ Other (please specify)

Registration Representative Signature: _____ Date: _____

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Assignment of Insurance Benefits/Eligibility Certification

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
For Medicare Patients ONLY		
Health Insurance Claim #	Part Effective Date	Part B Effective Date
Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address	Phone #	
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		
I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid to Valley Medicine Associate's for any medical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services.		

I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying my treatment. I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is Valley Medicine Associates. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full such charges.

_____	_____
Signature of Patient/ Responsible Party	Date
_____	_____
Name of Patient/Responsible Party (please print)	Relationship to Patient

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Communicating with You- (HIPPA)

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office.

We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice-mail.

Please check box that you give Valley Medicine Associates permission to use for your communications:

□ You may contact me by telephone Phone Number: _____
□ You may leave a message/voicemail Phone Number: _____
□ You may contact me by mail
□ You may contact me through email (My chart)

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship
1)	
2)	
3)	
4)	

_____ _____

Signature of Patient/ Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Diana Lozano, M.D.

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Agreement of Financial Responsibility

Thank you for choosing us as your new healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and pre-authorization requirements of your insurance company.

- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

- If we have a contract with your insurance company we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance cards for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and /or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/ Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient