J. Gabriel Guajardo, M.D.

When Caring for life, Every Stage Matters.

OBSTETRICS · GYNECOLOGY · INFERTILITY · INCONTINENCE

Patient Registration Form

PATIENT INFORMATION (Please Print)

Title (Mrs./Miss/Ms/Dr)_____ How did you hear about us? Referral? _____

Patient's Name (Last)_____ (First)_____(Middle)_____

Also Known As Name (Last)_____(First)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number _____ Date of Birth_____

Phone Numbers Home_____ Cellular_____Work_____Email_____

Address

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Emergency Contact Relationship to Patient_____

***Required Meaningful Use Information:**

Race (check one)_____American Indian or Alaskan Native_____Asian_____Native Hawaiian or Other Pacific Island_____White___Refuse to Report

Ethnicity (check one)_____Hispanic or Latino_____Not Hispanic or Latino_____Refuse to Report

Email_____

RESPONSIBLE PARTY INFORMATION (only if other than yourself)

Responsible Party Name (Last)_____ (First)_____ (Middle)_____

Social Security Number _____ ☐ Female ☐ Male Date of Birth_____

E-Mail Address_____

Phone Numbers Work_____ ☐ Day ☐ Evening Home_____ ☐ Day ☐ Evening

Address_____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Employer Phone Number_____

Patient ~~Relationship to Responsible Party~~_____City_____State_____ZIP_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____Date of Birth_____

SSN_____Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy No.)_____Group ID_____Copay Amount_____Effective Date_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured_____Date of Birth_____

SSN_____Patient Relationship to Insured_____

Insured Employer Name_____

Insurance Company/Phone Number_____ (_____)_____

Subscriber ID (Policy No.)_____Group ID_____Copay Amount_____Effective Date_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient Signature _____ ***Date*** _____

Or Legal Representative

Responsible Party Signature (if applicable) _____ ***Date*** _____

phone: 956.350.4821
fax: 956.350.6718
100B E. Alton Gloor Blvd., Suite 130,
Brownsville, TX 78526
GuajardoMD.com

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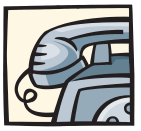
WELCOME TO OUR PRACTICE

Welcome

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal.

Thank you for choosing us as your healthcare provider. We look forward to caring for you!

Office Hours



Phones: Telephones are answered during normal business hours. After business hours, telephones are answered by the answering service. They will contact the physician in case of an emergency.

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday
8 a.m.- 5 p.m.	**8 a.m.- 6 p.m.**	**8 a.m.- 5 p.m.**	**8 a.m.- 5 p.m.**	**8 a.m.- 12 p.m.**

Emergencies: For life-threatening situations, call 911. If you have an urgent problem, please call our office (956) 350-4821 for instructions. After hours, our answering service will inform you of how to reach a physician on call.

Test Results: For test results call our office at (956) 350-4821.

Prescriptions: All prescriptions and refill requests should be requested during normal office hours. Please have your pharmacy call the office at (956) 350-4821 for renewal of medication.

About Our Physician

Juan Gabriel Guajardo, M.D.

- Specializing in Obstetrics and Gynecology.
- Offering services of Infertility Management.
- Graduate of University of Texas Medical Branch in Galveston, TX.
- Resident of Scott & White Medical Center located in Temple, TX.
- Born and raised in Brownsville, TX.
- Proud native of the Rio Grande Valley.

Appointments

For appointments please call (956) 350-4821.

- Please call in advance for routine office visits. Make follow-up appointments as you leave. We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.

phone: 956.350.4821
fax: 956.350.6718
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Brownsville, TX 78526

Insurance

- Prior to your appointment, please check your insurance information so you will be informed about referrals, co-payments, and any deductible required at the time of the visit.
- For your first visit, please bring your insurance card and arrive early to complete the necessary patient information forms.
- We accept Medicare and Medicaid as well as most insurers; however, please review all insurance information with our staff prior to services being rendered.
- Your health insurance contract is between you and your insurance company. Unfortunately, not all services are covered benefits. Some insurance companies arbitrarily select certain services they will not cover. Any complaints regarding your coverage should be directed to your carrier.

Financial Policy

- **We ask that all your services be paid the day of your visit**. If you have insurance, please present your insurance card for verification. If your insurance changes, please notify us immediately.
- **Co-payments, co-insurance, and any outstanding balances are expected at the time of service**. Patients may be financially responsible for payment of all services even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.
- **We accept Visa, Mastercard, American Express, Checks, and Cash**.
- If we are not participating providers with your plan, we will provide you with a receipt for you to file with your insurance company.
- Any check returned from the bank will result in an additional $40.00 charge.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/responsible party. Failure to promptly resolve this balance may result in third party collection and/or legal procedures will be taken.
- Please keep a close watch for carrier claim payment and contact the insurance carrier or the clinic practice manager at (956) 350-4821 in the event a claim is not resolved within 60 days from the date of service.
- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact our office Practice Manager at (956) 350-4821.

I HAVE UNDERSTOOD AND AGREE TO THE FINANCIAL POLICY FOR J. GABRIEL GUAJARDO, M.D. I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING, MEDICARE, MEDICAID, MY PRIVATE INSURANCE, TO J. GABRIEL GUAJARDO, M.D. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I AUTHORIZE J. GABRIEL GUAJARDO, M.D. TO RELEASE ALL MEDICAL INFORMATION REQUESTED BY MY HEALTH INSURANCE CARRIER, MEDICARE (SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES), MEDICAID, OR ANY OTHER THIRD PARTY PAYOR. I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS:

Print Name _____

Signature of Patient or Legal Representative _____ **Date** _____

What Do We Need From You?

- To inform the Medical Practice staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel, when necessary, with a phone call.
- To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days.
- To notify the Medical Practice of any change in his/her health status.
- To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.

What Should You Expect From Us?

- To be treated with respect, dignity and be informed about care needs to make appropriate decisions.
- Help plan care and make changes to it.
- Expect that teaching materials will be provided in a manner that can be understood.
- To be informed of the Medical Practice billing process.
- To keep records confidential except when consent has been given.
- To expect services to be professional, timely, and appropriate.
- To communicate complaints to the Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

Patient Consent

I HEREBY CONSENT TO THE ADMINISTRATION AND PERFORMANCE OF ALL TREATMENT, INCLUDING BUT NOT LIMITED TO ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS AND CULTURES, PERFORMANCE OF MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES.

I FULLY UNDERSTAND THAT THIS CONSENT IF GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMEMDED. THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT J. GABRIEL GUAJARDO, M.D. MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP. I UNDERSTAND AND ACKNOWLEDGE THAT J. GABRIEL GUAJARDO, M.D. WILL USE AND DISCLOSE MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS AS DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND AM ALSO AWARE IT IS AVAILABLE VIA THE INTERNET AT THE FOLLOWING WEBSITE: WWW.GABRIELGUAJARDOMD.COM.

Print Name _____

Signature of Patient or Legal Representative _____ **Date** _____

Whom to Contact

I HEREBY GIVE PERMISSION TO J. GABRIEL GUAJARDO, M.D. TO DISCLOSE OR DISCUSS ANY INFORMATION RELATED TO MY CONDITION(S) WITH THE FOLLOWING FAMILY MEMBER(S), SPOUSE, AND/OR CLOSE PERSONAL FRIEND(S).

NAME_____**RELATION**_____**PHONE** _____

NAME_____**RELATION**_____**PHONE** _____

NAME_____**RELATION**_____**PHONE** _____

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER TO DISCUSS PROTECTED HEALTH INFORMATION ABOUT ME (PLEASE CHECK WHAT YOU WISH TO BE APPLIED):

("Detailed Information" refers to your appointment time and date and/or information about your account, not your health condition)

HOME_____ **WORK**_____ **CELLULAR**_____

- ○ **OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION AT HOME.**
- ○ **OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION AT WORK.**
- ○ **OK TO LEAVE A MESSAGE WITH DETAILED INFORMATION ON THE CELL LISTED.**
- ○ **WRITTEN COMMUNICATION**
- ○ **OK TO MAIL TO MY HOME ADDRESS.**
- ○ **OK TO FAX TO THIS NUMBER** _____.
- ○ **OK TO EMAIL ME AT** _____.

Print Name _____

Signature of Patient or Legal Representative _____**Date**_____

Thank You.