RICARDO A. ABRAHAM, M.D.

Board Certified Internal Medicine

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☑ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / W

Is this your legal name? ☑ Yes ☐ No	If not, what is your legal name?	Race:	Birth date: / /	Age:	Sex: ☑ M ☐

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospit

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Email Adress:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance: ☐ Mcare ☐ TML ☐ BCBS ☐ Aetna ☐ Texas true choice

☐ United HealthCare ☐ Valley Health Plans ☐ Cigna ☐ Great west ☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payme $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I autorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Ricardo A. Abraham or insurance company to release any information required to process my clai

Patient/Guardian signature *Date*

RICARDO A. ABRAHAM, M.D.

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Consent for Purposes of Treatment, Payment, and Healthcare Operations

Parient's Name: ______________________ Date of Birth: ______________________

ID#: ____________________ SS#: ______________________________

I give permission to Dr. Ricardo A. Abraham & Staff to use or release my protected health information for the purpose of:

- Diagnosis or provision of treatment to me,
- Obtain payment for my health care bills, or
- Conduct health care operations.

My "protected health information" means health information, which"

- Includes my demographic information
- Has been collected for me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse, and
- Relates to my past, present, or future physical or mantal health or condition and identifies me, or there is a reasonable basis to belive the information may identify me.

I understand that my diagnosis or treatment by Dr. Ricardo A. Abraham & Staff may be conditional and dependent upon my signature on this form as proof of my consent. I understand I have rights, I have the right to ask for a limit as to how my protected health information is used or released to carry out treatment, payment, or healthcare operations of Dr. Ricardo A. Abraham & Staff. Dr. Dr. Ricardo A. Abraham & Staff is not require to agree to the limitations that I may ask for.

I have the right to withdraw thus consent, in writing, at any time, except to the exent that Dr. Ricardo A. Abraham & Staff has taken action based on this consent. I understand I have a right to review Dr. Ricardo A. Abraham & Staff Notice of Patients Privacy Rights. I can also ask for a copy of this form.

______________________________ ________ ______________________________

Signature of Patient or Legal Representative Date Print Name of Patient or Legal Representative

______________________________ ______________________________

Relationship to Patient, if signed by anyone other Witness

GENERAL MEDICAL RECORDS RELEASE AND AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete the following information:

PATIENT NAME: ____
ADDRESS: ____
____
PHONE: ______________________ SSN: ______________________ DOB: __________

I authorize the custodian or records of ____: or other person/entity (specifically describe) to disclose/release the following information. (check all applicable):

REQUESTING RECORDS FROM:

RICARDO A. ABRAHAM
3125 W. ALTON GLOOR
BROWNSVILLE,TEXAS 78526 PHONE: 956-544-5700 FAX: 956-350-9573

___ All Records
___ Laboratory/pathology records
___ X-ray/Radiology
___ Billing Records
___ Abstract/summary
___ Pharmacy/Prescription Records
___ Other (describe specifically) ____

The information may be used/disclosed for each of the following purposes:

___ At my request (only the patient can check this box)
___ For my health care
___ For payment/ insurance
___ For employment purposes
___ Other: ______________________________

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and 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, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

____
Signature of patient or patient's representative

____
Date

____
Printed name of patient's representative, parent Guardian

____
Representative's authority to sign for patient (power of attorney for healthcare)

HIPPA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices time to time and that I may contact this organization at any time at the address above to obtain a current copy of Notice 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 health care operations. I also understand you are not required to agree to me request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:______________________________

Relationship to Patient:______________________________

Signature______________________________

Date______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:____________ Initials__________ Reason______________________