☐ New Patient ☐ Updated Information

Medical Clinic HELOTES
Adult & Geriatric Specialist

Patient Demographics

Patient Name:_______________________________________ Birth Date:_____/______/_____
LAST FIRST MI

Social Security No: _________-_________-___________ Gender: ☐ Male ☐ Female

Address: ____
STREET ADDRESS CITY STATE ZIP

Home #: _____-_________-______ Cell #: ______-_______-________ Work #: _______-_______-_______

E-Mail Address: _____________________________________

Pharmacy: _______________ Phone: _________________ Cross Street: _______________

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _______________

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report
☐ Puerto Rican ☐ Mexican American ☐ Latin American ☐ Cuban ☐ Other _______________

Sexual Orientation: ☐Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Do Not Know
☐ Choose not to disclose ☐ Something else, please describe _______________________

Gender Identity: ☐ Female ☐ Male ☐ Female-to-Male ☐ Male-to-Female ☐ Chose not to disclose
☐ Additional gender category or other, please specify ______________________________
☐ Genderqueer, neither male nor female

Emergency Contact Information

Name: ____ Phone: ______-_______-______

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: ______________________ Relationship: ________________ Phone: ______________

Name: ______________________ Relationship: ________________ Phone: ______________

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:________________________________ Insured's Name:________________________

Policy #:__________________ Group #:______________ Insured's Date of Birth: ________________

Secondary Insurance

Secondary Company:______________________________ Insured's Name:_______________________

Policy #:__________________Group #:_______________ Insured's Date of Birth: ________________

Self-Pay Agreement

I agree to pay for medical services rendered from Alejandro Arizmendi, M.D., PLLC. I understand that payment must be made prior to establishing as a new patient.

Patient Signature: ____ Date: ____________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of ALEJANDRO ARIZMENDI, M.D., PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

______________________________	____________	____________________________________
Patient Name (Please Print)	Date	Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of ALEJANDRO ARIZMENDI, M.D., PLLC and affiliated providers may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____

Print Patient's Name

____

Print Name Legal Guardian

____

Date

Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable your health care providers at different locations to share individual patient medical information and discuss healthcare issues with their patients for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, prescribing, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way telephone or audio-video communication
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to protect its integrity against intentional or unintentional corruption.

COVID-19 Public Health Emergency Waiver

As enacted under the 1135 waiver provided by the Secretary of the Department of Health and Human Services and the Health and Human Services Office of Civil Rights (OCR) during the COVID-19 nationwide public health emergency, your health care providers may provide telemedicine services in good faith through everyday communication technologies even though these technologies may not fully comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Rules and as such may not provide protection of confidential identification or protected medical information. Your health care provider may use audio or video communication technology to provide telemedicine services during the COVID-19 nationwide public health emergency through any non-public facing remote communication product that is available to communicate with patients, such as FACETIME.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her home (or at a remote site) while the healthcare provider evaluates the patient, obtains test results and obtains necessary consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management without coming into the medical office.
- Obtaining prescriptions for necessary medications that my healthcare provider selects for me.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor audio or visual resolution of images) to allow for appropriate medical decision making by the healthcare provider(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: __________

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My health care provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including outside of San Antonio, Texas.
6. I understand that it is my duty to inform my doctor of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that my insurance deductibles and/or co-pays apply to telemedicine services or the telemedicine service is not covered I may be responsible for payment.
9. I understand that during the COVID-19 Nationwide Public Health Emergency my health care provider may use communication technologies that may not be provide protection of confidential identification or protected medical information.

Patient Consent To The Use of Telemedicine Services

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ***Helotes Medical Clinic*** to use telemedicine services in the course of my evaluation, diagnosis and treatment.

Patient Name: ______________________________________

Signature of Patient: _________________________________ Date:______________
(or authorized signer)

Authorized Signer: _________________________________
(relationship to patient)

Witness: ___________________________ Date:_______________

NEW PATIENT HEALTH QUESTIONAIRE

NAME: ____ DOB ___/___/___

ALLERGIES/SENSITIVITIES TO MEDICATIONS/REACTION:
____
____

REASON FOR VISIT: ____

Past Medical History: (Please check all that apply)

Deafness/Decreased Hearing	Asthma	Glaucoma	Hemorrhoids	NASH/ Fatty Liver
Heart Attacks	History of Tuberculosis	Kidney Disease	IBS/GERD	Gout
High Blood Pressure	Allergic Rhinitis	Kidney Stone	Stomach Ulcers	Dementia
Blood Transfusion	Epilepsy/Seizures	Venereal Disease	Migraines/Headaches	HIV
Anemia	Mental Retardation	Hypothyroidism	Osteoarthritis	Parkinson Disease
Bleeding Disorder	Cancer Type:	Hyperthyroidism	Rheumatoid Arthritis	Anxiety
High Cholesterol	Stroke/TIA	ADHD	Hepatitis B/C	Depression
COPD/Emphysema	Blindness/Cataracts	Type 1 Diabetes	Type 2 Diabetes	Other:

Immunizations:

	LAST KNOWN DATE
PNEUMONIA	
TETANUS	
FLU	
SHINGLES	

NEW PATIENT HEALTH QUESTIONAIRE

NAME: ____ **DOB** ___/___/___

Past Surgical History

Operations (including Biopsy)	**Year**	**Surgeon**	**Reason for Surgery**

Hospitalization (within the last 6 months)

Hospital	**Reason for Admission**

Family Medical History (List all that apply)

Relation	**Medical History**

For Women Only

Last Menstrual Period	**Method of Birth Control**	**#of Pregnancies**	**Live Births**
Miscarriages	**Abortions**	**Age of Menopause**	**Natural or Surgical** (pleas Circle one)

NEW PATIENT HEALTH QUESTIONAIRE

NAME: ____ **DOB** ___/___/___

Social History (Please circle all that apply)

Marital Status: **Single** **Married** **Widowed** **Divorced**

Living situation: **Live alone** **Lives w/family** **Lives with others**

Smoking: **Current smoker (everyday)** **Current smoker (some days)** **Former Smoker**

Never smoked **______ packs/day** **______ years smoked**

Alcohol Use: (Please circle all that apply)

Yes **No**

Heavy Drinker (1-5 drinks/day) **Moderate Drinker (1-5 drinks/wk)**

Occasional Drinker

Recreational Drugs Use: (Please circle all that apply)

Yes **No**

Heavy User **Moderate User** **Occasional User**

List type of recreational drug used: ____

Periodic Exams (Please list date/result and Where)

Mammogram Date: **Normal or Abnormal**	**Colonoscopy Date:** **Normal or Abnormal**	**Occult card/Cologuard kit** **Normal or Abnormal**
Pap Smear Date:	**EKG:**	**Eye Exam Date:**
Chest X-ray:	**Blood Work:**	**Falls: YES NO**

NEW PATIENT HEALTH QUESTIONAIRE

NAME: ____ DOB ___/___/___

Current Medications

List **ALL** medications that you are currently taking including Non -Prescription Medications & Herbal remedies.

(Please DO NOT substitute a List Please write Below)

Medications	Dose	How Often	Approx. Start Date

If taking ADD/ADHD medications Please leave Psychiatrist Info below to Confirm Diagnosis

Name: ___________________________________Phone: _______________________

Date Last Seen: _______________________

Authorization for Release of Medical Information

Patient Full Name___________________________________ DOB___/___/___ SSN___________________
Previous/Another Name (if different than listed above) ____

This will authorize:

Practice Name: ______________________________
Address: ___________________________________
City, State, Zip: ____________________________
Phone: ____________________________________
Fax: _________________________________

To release to:

Practice Name: Helotes Medical Clinic
Address: 12002 Bandera Rd Suite 111
City, State, Zip: Helotes, Texas, 78023
Phone: 210-695-9002
Fax: 210-695-9044

Medical Records Requested From (dates): ____________________ to ________________________

--OR--

List specific records requested (labs, imaging, progress notes, etc.) ___________________________________

(if this section is left blank, a summary of records from the last 2 years will be provided)

Reason for release: ____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED BY STATE OR FEDERAL LAW
I specifically authorize the release of data and information relating to (check yes or no):
YES NO

___ ___ Substance abuse (alcohol/drug abuse)

___ ___ Mental health/depression (includes psychological testing)

___ ___ HIV-related information (AIDS related testing)

This consent may be revoked at any time by notifying the above-named provider of information in writing. This release will expire 1 year after date on this form, unless another date is specified here: ______________________________, in which case release will expire on specified date. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.
I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I understand I do not have to sign this authorization in order to obtain health care services.
FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records.

____
Signature of patient or authorized representative
Date ___/___/___