Palacios Family Medicine
Patient Intake Form

Name:_____ **D.O.B.:**_____**S.S.**_____

Marital Status: ___Single__Married___Divorced__Widowed **Gender:**___Male___Female

Race:___White___Afrian-American___Asian___Other **Language:**___English___Spanish__Other

Ethnicity:____Hispanic___Non-Hispanic **E-Mail:**_____

Physical Address: _____
Name City State Zip Code

Mailing Adress:_____
Name City State Zip Code

Home #:_____**Cell#**_____**Other:**_____

Perferred Method of Contact for Automated Appt Confirmation Sustem ____Home___Cell___Text

Emergency Contact_____**Relation**_____**Phone**_____

Preferred Pharmacy_____**Location**_____**Phone**_____

Employer_____ **Occupation**_____

Phone#_____ Ext:_____

Address_____
Name City State Zip Code

MEDICAL INSURANCE INFORMATION (Please provide insurance card(s) to Front Desk)

_____**Self Pay** _____**Private Insurance** _____**Medicare** _____**Medicaid**

Guaranter_____**D.O.B.**_____**S.S.**_____

Insurance Co._____**ID#**_____**Group#**_____

PATIENT RIGHTS & RESPONSIBILITES/PRIVACY NOTICE

I have read the patient's Rights & Responsibilites and Privacy Notice. I undertand that I can receive a copy of the document at any time.

ASSIGNEMENT OF BENEFITS & RELEASE OF INFORMTION

I authorize the release of any medical information necessary to process the claim for services rendered to me. Assignment of benefits will be paid to Palacios, MD PA Family Medicine. I am aware of my responsibility to pay any balance of service that my insurance may not cover. By signing below, I acknowlege that all information is correct and that I understand all responsibilites.

X:_____

Melva Palacios, MD PA
2722 W. Canton Rd.
Edinburg, TX 78539
Phone: (956) 383-4157 · Fax: (956) 383-5457

PATIENT AUTHORIZATION

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

Patient health information including but not limited to diagnosis, patient records, examinations rendered, billing information, and appointments.

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed to:

_____
Name of Person Relationship

_____
Name of Person Relationship

PATIENT RIGHTS

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all the above policies, please sign your name below

_____
Patient or Legally Authorized Individual Signature Date

_____
Print Patient's Full Name Time

_____
Witness Signature Date

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Consent to Use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Palacios Family Medicine or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practice for more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.
_____Patient Initials

Requesting a Restriction on the Use of Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas
Open or common areas are at times used to discuss Patient Health Information. Private areas are available for privacy upon request.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date