MARIO R. ANZALDUA, M.D.

PLEASE PRINT

CONFIDENTIAL

PATIENT INFORMATION

PATIENT NAME ____ **D.O.B.:** _______________ **S.S. #** __________________

HOME ADDRESS ____ **CITY**____________ **STATE** _____ **ZIP** _____________

HOME PHONE: _______________________ **WORK PHONE:** ______________________ **CELL PHONE:** ____________________

E-Mail ADDRESS # __________________ ____ **MINOR** ____ **SINGLE** ____ **MARRIED** ____**DIVORCED** ____ **WIDOWED** ____**SEPERATED**

NAME OF EMPLOYER____

EMPLOYER ADDRESS ____ **CITY**____________ **STATE** _____**ZIP** ____________

IF STUDENT, NAME OF SCHOOL OR COLLEGE ______________________________________ **CITY** _______ **STATE** _______

WHOM MAY WE THANK FOR REFERRING YOU? ____

INSURANCE INFORMATION

NAME OF POLICYHOLDER ____ **D.O.B.:** __________ **S.S. #** __________________

RELATION TO POLICYHOLDER ______ **SELF** ______ **SPOUSE** ______ **CHILD** ______ **OTHER** **SPECIFY IF OTHER** ___________________

POLICYHOLDER'S EMPLOYER ____ **WORK PHONE** _________________

EMPLOYER ADDRESS ____ **CITY** ___________ **STATE** ______ **ZIP** __________

IF YOU DO NOT HAVE A COPY OF YOUR INSURANCE CARD, PLEASE PROVIDE THE FOLLOWING:

NAME OF INSURANCE COMPANY ____ **PHONE** ___________________

INSURANCE ADDRESS TO SUBMIT MEDICAL CLAIMS:

____**CITY** _________________**STATE** _________ **ZIP** __________

POLICY ID # ____ **GROUP** ____

*****NOTE: If unable to provide this information, you are unable to see the doctor.******

RESPONSIBLE PARTY

IF PATIENT IS UNDER AGE PLEASE PROVIDE INFORMATION OF THE PARENT/LEGAL GUARDIAN.

RELATION TO PATIENT ______ **SELF** ______ **SPOUSE** ______ **CHILD** ______ **OTHER** **SPECIFY IF OTHER** ___________________________

NAME ____ **BIRTHDATE** __________ **S.S. #** _________________

HOME ADDRESS ____ **CITY**________________ **STATE** _______ **ZIP** ____________

HOME PHONE: _____________________ **WORK PHONE:** ______________________ **CELL PHONE:** _______________________

DRIVERS LICENSE # / STATE ID # _______________________

EMERGENCY CONTACT

NAME ____________________________________ **RELATIONSHIP:** _____________ **HOME** _____________ **CELL**_____________

NAME ____________________________________ **RELATIONSHIP:** _____________ **HOME** _____________ **CELL**_____________

FINANCIAL AGRREMENT

PAYMENT IS EXPECTED IN FULL AT EACH APPOINTMENT, ARRANGEMENTS AVAILABLE ONLY FOR SPECIAL PROCEDURES.
FOR YOUR CONVENIENCE, WE OFFER THE FOLLOWING METHODS OF PAYMENT. PLEASE CHECK THE OPTION YOU PREFER.

______________ **CASH** ______________ **CHECK** ______________ **CREDIT CARD**

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

____ _____________________________

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

Mario R. Anzaldua, M.D.

Family Practice
1512 E. Griffin Parkway Ste. 2
Mission, Texas 78572

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTION HEALTH INFORMATION

With my consent, Mario R. Anzaldua, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Mario R. Anzaldua, M.D.'s Notice of Privacy Practices for 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. Mario R. Anzaldua, M.D. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Mario r. Anzaldua, M.D. Privacy Officer at 1109 Pamela Dr. Mission, Texas 78572.

With my consent, Mario R. Anzaldua, M.D. may call my home or other designated location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Mario R. Anzaldua, M.D. may mail to my home or other designated location any items that assist the practice in carrying gout TPO, such as appointment reminder cards and patient statements as long as they are marked personal and Confidential.

With my consent, Mario R. Anzaldua, M.D. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Mario R. Anzaldua, M.D. restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Mario R. Anzaldua, M.D's 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, Mario R. Anzaldua, M.D. may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

__________________________________ ____________________
Patient's Name **Date**

____
Print Name of Patient or Legal Guardian

MARIO R ANZALDUA, M.D.
1512 E GRIFFIN PARKWAY STE 2
MISSION, TEXAS 78572
956-519-7088 FAX: 956-519-9816

IMPORTANT INFORMATION REGARDING MEDICARE AND CHRONIC CARE MANAGEMENT

Dear Patient,

We enjoy and appreciate the opportunity to provide you with comprehensive primary care. Medicare has identified the care of chronic health conditions as an important goal. Chronic conditions are ongoing medical problems that must be managed effectively in a partnership between the health care team and the patient to maintain the best possible health. Examples include diabetes, high blood pressure, heart disease, depression, and others. Effective Jan. 1, 2015, federal regulations now enable Medicare to pay for chronic care management.

What is chronic care management?
Your physician and primary care team will carefully monitor and provide comprehensive care for your chronic health conditions in a systematic way to supplement regular office visit care.

How can you benefit from chronic care management?

- You will have 24/7 access to your primary care team.
- You will have preventive care services scheduled, many of which are covered by Medicare, and your medications will be closely monitored.
- You will receive a personalized, comprehensive plan of care for all of your health issues.
- Your care will be coordinated by your physician and staff, including care you may receive at other locations, such as specialists' offices, the hospital, other health care facilities, or your home.

What do you need to know before signing up?

- Understand that this care requires you to pay approximately $8 to $9 (your Medicare coinsurance amount) to your primary care practice each month that you receive chronic care management. The service is also subject to your Medicare deductible.
- You must sign an agreement to receive this type of chronic care management.

Please let us know if you have questions about this new benefit or would like to receive the one-page agreement form.

Sincerely,
MARIO R ANZALDUA, MD.

MARIO R ANZALDUA, MD.
1512 E GRIFFIN PARKWAY STE 2
MISSION, TEXAS 78572
956-519-7088 fax 956-519-9816

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

• Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (e.g., email),

• The ability to get successive, routine appointments with my designated primary care physician or member of my care team,

• Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,

• Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,

• Management of my care as I move between and among health care providers and settings, including the following:

Referrals to other health care providers,

Follow-up after I visit an emergency department,

Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),

• Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that Mario R. Anzaldua, MD. is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print):

____

Patient or guardian signature:

____

Date: ____

To: ____________________________ ______________________
(Patient Name) (Date)

I, Mario R. Anzaldua M.D., own an ownership or investment interest in Doctors Hospital at Renaissance, Ltd. I am referring you to Doctors Hospital at Renaissance for treatment or testing. If you object to the referral or have any questions about the notice, please let me know. This notice is given to you a required by federal law and
the hospital's rules and regulations.

Receipt acknowledged: ____
(Patient Signature)