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: _____

FAMILY RELEASE OF INFORMATION

MEDICAL RELEASE OF INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY REQUEST AND AUTHORIZE:

MARIO R. ANZALDUA, M.D.
1512 East Griffin Parkway Ste #2
Mission, Texas 78572
956-519-7088
956-519-9816 fax

TO RELEASE MY MEDICAL INFORMATION AND RECORD TO:

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

REASON FOR DISCLOSURE
(Choose only one option below)

_____ Treatment/Continuing Medical Care _____Personal Use _____Billing or Claims _____Insurance
_____Legal Purposes _____Disability Determination _____School _____ Employment
_____Other _____

WHAT INFORMATION CAN BE DISCLOSED?
Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

All health information
_____History/Physical Exam _____Past/Present Medications _____Lab Results _____ Physician's Orders
_____Patient Allergies _____Operation Reports _____Consultation Reports _____Progress Notes
_____Discharge Summary _____Diagnostic Test Reports _____EKG/Cardiology Reports _____Pathology Reports _____Billing Information _____Radiology Reports & Images
_____Other_____

Your initials are required to release the following information:
_____Mental Health Records (excluding psychotherapy notes)
_____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):
Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
PATIENT SIGNATURE **DATE**

_____ _____
LEGAL GUARDIAN/ RELATION **DATE**

MARIO R ANZALDUA, M.D.
1512 East Griffin Parkway Ste. #2
Mission, Texas 78572
956-519-7088 956-519-9816 fax

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY REQUEST AND AUTHORIZE:

TO RELEASE THE MEDICAL RECORDS FOR THE PATIENT NAMED ABOVE TO:
MARIO R. ANZALDUA, M.D.
1512 East Griffin Parkway Ste #2
Mission, Texas 78572
956-519-7088
956-519-9816 fax
THIS INFORMATION IS BEING DISCLOSED FOR THE PURPOSE OF CONTINUATION OF MEDICAL CARE

PLEASE RELEASE THE FOLLOWING:

DATE TO DATE		
COMPLETE HEALTH RECORD		
HISTORY & PHYSICAL		
PROGRESS NOTES ONLY		
HOSPITAL DISCHARGE SUMMARY OR NARRATIVE		
IMMUNIZATION RECORD		
LABORATORY		
X-RAY REPORT OR FILMS		

I UNDERSTAND THIS INFORMATION MAY CONTAIN INFORMATION RELATING TO: (Circle if Applicable)
Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV)
Mental Health Alcohol/Drug Abuse

I understand that I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

UNLESS OTHERWISE INDICATED, THIS AUTHORIZATION WILL EXPIRE IN NINETY (90) DAYS FROM THE DATE OF SIGNATURE. THE PHYSICIAN AND EMPLOYEES ARE RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN

I understand that there may be a fee for preparing and furnishing this information.

_____ _____
PATIENT SIGNATURE

_____ _____
LEGAL GUARDIAN/ RELATION