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MINIMALLY INVASIVE SURGERY OBSTETRICS + GYNECOLOGY

PATIENT UPDATE FORM

PATIENT INFORMATION *Informacion del Paciente*

Name (Last, First, MI) *Nombre del Paciente*			**Date of Birth** *Fecha de Nacimiento*
Home Address *Direccion del Hogar*		**City** *Ciudad*	**State** *Estado* / **Zip Code** *Codigo Postal*
Home Phone *Telefono del Hogar*	**Work Phone** *Telefono del Trabajo*	**Mobile Phone** *Telefono Portatil*	**E-mail Address** *Direccion de E-mail*
Best contact number *contacto principal*			

INSURANCE INFORMATION *Informacion de Seguro*

Primary Insurance Company *Nombre del Seguro*	**Group #** *# de Grupo*		**Policy #** *# de Poliza*
Subscriber's Name *Asegurado*	**Relationship** *Relacion*	**Social Security #** *Seg. Social*	**Date of Birth***Fecha de Nacimiento*
Secondary Insurance Company *Nombre del Seguro*	**Group #** *# de Grupo*		**Policy #** *# de Poliza*
Subscriber's Name *Asegurado*	**Relationship** *Relacion*	**Social Security #** *Seg. Socia*	**Date of Birth***Fecha de Nacimiento*

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, MasterCard, American Express, and Discover Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card, American Express y Discover. Su segurdo medico es un contrato entre usted y su compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta dueda, usted es responsible de los gastos legales.

PHYSICIAN'S RELEASE AND ASSIGNMENT:

I hereby assign payment directly to Alvarez & Vinueza, MDs, LLC. of all payments applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Alvarez & Vinueza, MDs, LLC. I understand that I am financially responsible to Alvarez & Vinueza, MDs, LLC for any and all charges that the carrier declines to pay (including but not limited to: Not a covered benefit, Disallowed by plan). I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Alvarez & Vinueza, MDs, LLC todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de recibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi seguro medico.

Signature of Patient *Firma del Paciente*: **Date** *Fecha*:

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Notice of Privacy Acknowledgement/ Aviso De Privacidad Reconocimiento

Alvarez & Vinueza, MDs, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Entiendo que bajo el Health Insurance Portability and Accountability Act (HIPAA), tengo ciertos derechos a la privacidad con respecto a mi información de salud protegida. Reconozco que han recibido o han tenido la oportunidad de recibir una copia de su aviso de prácticas de privacidad. También entiendo que esta práctica tiene el derecho de cambiar su aviso de prácticas de privacidad y que puedo contactar con la práctica en cualquier momento para obtener una copia actual de la notificación de prácticas de privacidad.

CONTACTS FOR RESULTS/ CONTACTOS PARA OBTENER RESULTADOS:

Patient telephone numbers/ Números de teléfono del paciente:

_____ _____ _____

Home Phone/*Teléfono de casa* Work Phone/*Teléfono de trabajo* Mobile Phone/*Teléfono móvil*

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to fax medical information needed for my treatment to the following fax number (*Yo autorizo a Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina que manden cualquier información necesaria para mi tratamiento medico al siguiente número de fax)*:

_____

Fax Number/ *Número de fax*

I authorize Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza and any members of their staff to discuss my medical information including test results with the following individuals (*Yo autorizo que el Dr. Wilfredo J. Alvarez, Dr. Cesar A. Vinueza y los empleados de la oficina pueden hablar sobre mi información médica incluyendo resultados de pruebas con las siguientes personas)*:

_____ _____

Name/*Nombre* Relationship to Patient/*Relación a paciente*

_____ _____

Name/*Nombre* Relationship to Patient/*Relación a paciente*

_____ _____

Name/*Nombre* Relationship to Patient/*Relación a paciente*

Signed/ *Firmado*:

_____ _____

Patient Name or Legal Guardian (print)/ Date/*Fecha*
Nombre del paciente o la Legal de guarda (impresión)

_____

Signature/*Firma*

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____ **FOR OFFICE USE ONLY**

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ANNUAL UPDATE QUESTIONAIRE

Name/Nobre:_____ Today's Date/La fecha de hoy:_____

Date of Birth/fecha de nacimiento:_____ Age/edad:_____

Occupation/ocupacion:_____ Marital Status/estado civil:_____

Reason for your visit today/la razon de su visita de hoy?_____

List any new illnesses since your last visit/anote las nuevas enfermedades desde su ultima visita:
_____

List any surgeries or procedures since your last visit/anote cuales cirugias o procedimientos desde su ultima visita:
_____

List any hospitalization since your last visit/ Una lista de cualquier hospitalizacion desde su ultima visita:
_____

Current Medications and Supplements/medicamentos y suplementos actuales:
_____

Allergies/alergias:_____

Do you smoke cigarettes/fuma cigarillos? [ ] yes [ ] no

If so, How many/en caso affirmative, cuantos?_____

How much alcohol do you drink/cuanto alcohol bebe?
_____daily/diario, _____ weekly/semanal, _____monthly/mensual, _____yearly/anual

Do you exercise regularly/hace ejercicio regularmente? [ ] yes [ ] no

Are you having normal menstrual cycles/tiene ciclos menstruales normales?
[ ] yes, last menstrual period/la ultima menstuacion:_____ [ ] no, abnormal/anormal
[ ] menopausal/menopausico

Are you sexually active/es usted sexualmente acitiva? [ ] yes [ ] no

Current contraception/anticoncepcion actual:_____

If so, do you have a new partner since your last GYN evaluation/si es asi, tiene unanueva paraja desde su ultima evaluacion de ginecologo? [ ] yes [ ] no

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ANNUAL UPDATE QUESTIONAIRE (page 2):

Do you have concerns about sexually transmitted diseases/tiene alguna preocupacio acerca de las enfermedades de transmission sexual? [ ] yes [ ] no

Do you have any concerns about contraception/tiene alguna preocupacion acerca de la anticoncepcion? [ ] yes [ ] no

Are you considering pregnancy in the next 12 months/esta considerando el embarazo en los proximos 12 meses?
[ ] yes [ ] no

Are there any changes in your family history/hay algun cambio en su historia familiar en caso affirmative, indique aqui?
[ ] yes [ ] no If yes, please list here:
_____

Last Pap Smear/ultima prueba depapanicolaou: _____

Last mammogram (if over 40 years old)/ultima mamografia (si mas de 40 anos de edad): _____

Have you had the following vaccines/ha tenido las siguientes vacunas?:

1.Tdap booster (tetanus, diphtheria, pertussis/tetano, difteria, la tos ferina) in the last 10 years?
[ ] yes [ ] no

2.Hepatitis A and B?
[ ] yes [ ] no

Who is your primary care physician/quien es su medico de cabecera? _____

PCP Telephone Number/numero de telefono de su medico:_____

When was your last colonoscopy? _____

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NOTICE REGARDING INSURANCE/ HOSPITAL AFFILIATION

Dear Patient,

Please be advised that there are certain insurances that we accept in our office that may not be accepted at other facilities such as Baptist Hospital. Dr. Alvarez and Dr. Vinueza only have privileges at Baptist Hospital (Main) and MASC (Baptist's Medical Art Surgery Center). It is your responsibility to verify hospital/facility affiliation with your insurance company. Should you require any service which needs to be provided outside of our offices, it may become necessary to transfer your care to another physician (who has privileges at a facility which is in-network with your insurance).

I (print name) _____, have read, understand and agree to the above terms.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____
Witness (Print Name)

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WAIVER REQUESTING LAB TESTS OUTSIDE MY HEALTH INSURANCE COMPANY COVERAGE

I acknowledge that although I may have health insurance which will pay for laboratory tests if I go to the specific local lab designated by my insurance company, I request that **Alvarez & Vinueza M.D's, L.L.C.** perform these tests through this office. My doctor and/or his staff have explained that I may go to the lab with a prescription and have the test(s) done at no charge. However, I request that the test(s) be performed through my Doctor's office despite the cost I shall incur.

This is being done entirely for my convenience and as a courtesy to me.

☐ **I agree that today I will pay the $25.00 administrative fee necessary to perform the specific test through my Doctor's office.**

_____ _____
Signature of patient Date

_____ _____
Signature of witness Date

☐ **I do not wish to have Alvarez & Vinueza, M.D.'s, LLC perform any laboratory tests.**

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Dear Patient,

The health insurance industry allows physician practices, such as ours, to submit a medical claim on your behalf for the payment of services and treatment provided. Insurance companies often do not notify us of a patient balance until many months after your visit. Because of this, we (like many other physicians, hotels and car rental agencies) request that you provide us with a valid credit card to keep on file to make it easier for you to pay off your balance, if it becomes necessary. This information will be kept confidential. Should you have additional charges or a balance after your insurance company processes our claim, we will send you a statement showing the balance. If, after 30 days from the statement date, we haven't received a payment for the balance, we will then submit the charge through the credit card we have on file for you.

If you request, we can provide an **estimate** for the services rendered. Please understand that this is an **estimate only** and your actual charges and / or responsibility may be more or less than the estimate, depending upon the services performed and coverage actually provided by your insurance company. In some circumstances, additional charges may be incurred after your departure from the office and not included in the estimate. This may occur when a more complete review identifies charges that were missed initially. In addition, the information we initially receive from your insurance company prior to your visit regarding coverage and your responsibility is often different than the information we receive after the claim has been formally submitted.

When making decisions regarding your medical care, we make the best decisions we can given your particular circumstances. However, some insurers will only pay for a limited number of procedures, even if they are considered medically necessary. Insurers allow direct patient billing for uncovered services. If your insurance does not cover a service, you will be responsible for the balance. If you have a question whether you are receiving a covered service, please ask. . . however, we are sometimes unable to get accurate information from insurers prior to the formal submission of a claim, which cannot occur until after the procedures have been performed. Our inability to get valid information from the insurer will not change your obligation for the balance, if one results.

I (print name) _____, have read, understand and agree to the above terms.

_____ _____

Patient Signature Date