Richard A. Benavides, M.D.
7920 Belt Line Rd. Ste. 310
Dallas, TX 75254
972-331-8100
972-331-8110 fax

PATIENT NAME_____ **DATE OF BIRTH**_____/_____/_____
Last First MI

SOCIAL SEC. #_____ **MARITAL STATUS:** S M W D **SEX:** FEMALE / MALE

ADDRESS_____
Street or Box City State Zip

PHONE (H) _____**(W)**_____ **(C)** _____**Email**_____

EMPLOYER_____ **WHO REFERRED YOU TO US**_____

SPOUSE'S NAME_____
Last First M.I.

SPOUSE'S SOCIAL SEC. # _____ **SPOUSE'S DATE OF BIRTH**_____/_____/_____

NEAREST FRIEND OR RELATIVE THAT <u>DOES NOT</u> LIVE WITH YOU FOR EMERGENCY CONTACT

NAME _____**RELATIONSHIP**_____

PHONE(Home) _____**(Work)**_____ **(Cell)** _____

PLEASE COMPLETE IF PATIENT IS A MINOR OR A STUDENT:

MOTHER'S NAME_____ **DATE OF BIRTH**_____**HM PH.**__ _____

ADDRESS _____**WK PH.** _____

EMPLOYER _____**SOCIAL SEC. #** _____

FATHER'S NAME _____**DATE OF BIRTH** _____**HM PH.**_____

ADDRESS _____**WK PH.** _____

EMPLOYER _____**SOCIAL SEC. #** _____

PRIMARY INSURANCE_____**ID#**_____**GROUP#**_____

INSURED NAME _____**DOB**_____**RELATIONSHIP**_____

IS THIS THRU AN EMPLOYER?___ **IF SO, WHO?**_____

ANY SECONDARY INSURANCE? _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DR. RICHARD BENAVIDES. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

<u>SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF PATIENT IS A MINOR</u> **DATE:**

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Patient Name _____ **Date of Birth**_____/_____/_____

HT: _____**WT:**_____**BMI:**_____

REASON FOR TODAY'S VISIT (Brief Description):
_____

PREVIOUS HOSPITALIZATIONS & ALL SURGICAL PROCEDURES, PLEASE LIST YEAR:
(a) _____
(b) _____
(c) _____

PLEASE LIST ALL MEDICAL PROBLEMS PAST & CURRENT:
(a) _____
(b) _____
(c) _____
(d) _____

LIST ALL MEDICATIONS YOU TAKE (including non-prescription drugs):
(a) _____ **(d)** _____
(b) _____ **(e)** _____
(c) _____ **(f)** _____

ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS?_____
IF YES WHAT?_____

DO YOU HAVE ANY MEDICATION ALLERGIES? YES OR **NO**
IF SO, PLEASE LIST THE MEDICATION *AND REACTION*_____

FAMILY HISTORY:
FATHER: AGE:_____ **STATE OF HEALTH:** _____
CAUSE OF DEATH, IF DECEASED:_____
MOTHER: AGE:_____ **STATE OF HEALTH:** _____
CAUSE OF DEATH, IF DECEASED:_____

ILLNESSES THAT RUN IN THE FAMILY? _____
_____

SOCIAL HISTORY:
EDUCATION: _____ **OCCUPATION:** _____
TOBACCO: _____ **PACKS/DAY** **ALCOHOL:**_____**DRINKS/DAY**

ARE THERE ANY OTHER PROBLEMS WITH YOUR HEALTH THAT YOU FEEL ARE IMPORTANT FOR THE DOCTOR TO KNOW ABOUT? _____

ALL INFORMATION LISTED ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE_____ **DATE**_____

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DISCLAIMER: **Please understand** that the following information **has to be provided, initialed and signed by all patients** of Dr. Richard Benavides.

PRIVATE PAYING PATIENTS without insurance have been informed of what is included in *their price package.*

_____Fees for Anesthesia, the Surgery Facility and/or the Assistant Surgeon are not billed by our office but will be billed by each provider if required.

_____Services are rendered to the patient, not the insurance company. As a courtesy, our insurance representative will file your insurance claim if proper information is received by the patient. It is your responsibility to see that your insurance company pays the claim.

If you are paying for services as a cash patient, NO insurance will be filed. I understand that if my insurance or Medicare policy decides not to pay a claim, I am financially responsible for all charges for services and products to me, including the balance remaining after any payment of insurance benefits. I agree to keep my account in good standing and pay my balances in a timely manner. I authorize payment of medical benefits to Richard A. Benavides, M.D. I authorize the release of any medical information necessary to process claims.

In connection with pursuing medical care, our insurance representative may require medical records. I hereby grant Dr. Richard A. Benavides, permission to release all of my medical records to his insurance representative and any insurance company in which I am covered. This release includes all medical records including, but not limited to: psychiatric records, cardiac records, records from my primary care physician or any other physician or hospital, drug and/or alcohol records, HIV and/or STD records, lab results and/or sleep related records. I understand that his insurance representative may not be a part of the office of Dr. Richard A. Benavides.

I have read, understand and agree to the above information.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF PATIENT IS A MINOR **DATE**

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HIPAA CONSENT FORM

Patient Name _____ Date of Birth _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**
IF PATIENT IS A MINOR

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In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with the billing office or the office manager. We are dedicated to providing the best possible care and service to you. **We believe your complete understanding of the financial responsibilities as a patient is an essential element of your care and treatment.**

Full payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we will accept cash, check, or money order. If you are paying cash for surgery, you must pay by cashiers check only.

Insurance

We have arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans for which we have an agreement with. It is your responsibility to see that your claims are paid in a timely fashion. It is our policy to collect your financial responsibility when you arrive for your appointment.

Returned Checks

A $35.00 service charge will be added to your account for all retuned checks. The amount of the returned check plus the $35.00 service charge must be paid before additional appointments will be scheduled. Restitution of the check must be made within ten calendar days or the returned check will be given to the county attorney for prosecution.

Collection Agency

Any account that is given to our collection agency due to non-payment will have a 10% collection charge added to the balance. Our collection agency will then will then collect balance plus the 10% collection charge.

Services Rendered in the Hospital

We will bill your health plan for services provided to you by Dr. Benavides while in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office. If you are unable to pay in full, payment arrangements may be made with our billing office.

Minor Patients

For all services rendered to a minor patient, we will look to the adult accompanying the patient and/or the parent or guardian with custody for payment.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THE PRACTICE AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF PATIENT IS A MINOR **DATE**

_____

PRINTED NAME OF THE PATIENT