



# Renaissance Women's Healthcare, P.A.

5115 S. McColl Rd. Edinburg, Texas 78539

*Jim Garza, M.D., F.A.C.O.G.    Rebecca M. Guerra, M.D., F.A.C.O.G.*  
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## Registro del Paciente

Nombre: \_\_\_\_\_ Número social: \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_ Edad: \_\_\_\_\_ Estado Civil:  Casada  Divorciada  Separada  Viuda  Soltera

Raza: \_\_\_\_\_ (Caucasiano, Negro, Hispano, Asiatico, Blanca, Anglosajon) Origen Étnico \_\_\_\_\_ (Latino/Hispano, Otro)

Persona responsable si la paciente es menor de edad: \_\_\_\_\_

Domicilio: \_\_\_\_\_ Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código: \_\_\_\_\_

Teléfono: (\_\_\_\_) \_\_\_\_\_ Celular: (\_\_\_\_) \_\_\_\_\_ Correo electrónico \_\_\_\_\_

Empleador: \_\_\_\_\_ Teléfono: (\_\_\_\_) \_\_\_\_\_

Dirección: \_\_\_\_\_ Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código: \_\_\_\_\_

Nombre de esposo o tutor: \_\_\_\_\_ Numero social: \_\_\_\_\_

Dirección \_\_\_\_\_ Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código: \_\_\_\_\_

Fecha de nacimiento: \_\_\_\_\_ Teléfono (\_\_\_\_): \_\_\_\_\_ Relación al paciente: \_\_\_\_\_

Estudiante:  Tiempo Completo  Medio Tiempo Trabajo:  Tiempo Completo  Medio Tiempo

Si la paciente es estudiante, nombre de escuela o colegio: \_\_\_\_\_

Contacto de emergencia: \_\_\_\_\_ Tel: (\_\_\_\_) \_\_\_\_\_ Relación al paciente: \_\_\_\_\_

Referido por: \_\_\_\_\_

Farmacia preferida: \_\_\_\_\_ Dirección: \_\_\_\_\_

*Acepta transfusión de sangre? \_\_\_\_\_ Si \_\_\_\_\_ No (Si NO acepta, favor de avisar a la recepcionista antes de ver al doctor)*

## INFORMACIÓN DE SEGURO

Seguro primario: \_\_\_\_\_ Empleador \_\_\_\_\_

Nombre del asegurado: \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_

Numero social: \_\_\_\_\_ # de ID \_\_\_\_\_ # de grupo: \_\_\_\_\_

Relacion al paciente:  Misma  Esposo  Hijo/a  Padres

Seguro primario: \_\_\_\_\_ Empleador \_\_\_\_\_

Nombre del asegurado: \_\_\_\_\_ Fecha de nacimiento \_\_\_\_\_

Numero social: \_\_\_\_\_ ID# \_\_\_\_\_ # de grupo: \_\_\_\_\_

Relación al paciente:  Misma  Esposo  Hijo/a  Padres

***La información proveida es cierta y correcta. Yo entiendo que soy responsable de todos los cargos que se deban.***

Firma de la paciente: \_\_\_\_\_ Fecha: \_\_\_\_\_



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**CONSENT FOR TREATMENT / PRIVACY POLICY /  
ASSIGNMENT OF BENEFITS**

The undersigned being the patient and/or guaranteeing party to the above-named account hereby acknowledges and agrees to the following:

**I. CONSENT FOR TREATMENT:** I hereby consent to the evaluation and management services provided by \_\_\_\_\_ of Renaissance Women's Healthcare, P.A. within this facility. Services may include diagnostic radiology and lab services. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION:** The undersigned hereby authorizes Renaissance Women's Healthcare to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such health care claims. Further, the undersigned releases Renaissance Women's Healthcare to provide to outside health care providers/services such information as is necessary to facilitate proper health care, limited only to that which is deemed minimally necessary to execute referrals, etc. on behalf of the patient. In addition, by copy of this document, the patient consents to the release of prior medical records from referring physicians, hospitals, nurses or other entities, which have records necessary for proper evaluation and treatment of the patient.

**III. PRIVACY STATEMENT:** The undersigned hereby acknowledges the privacy policy of Renaissance Women's Healthcare. Renaissance Women's Healthcare will administer our patient records in a confidential manner and in compliance with the Health Insurance Portability and Privacy Act. Any and all patient information will only be released with proper authorization. Patient information shall not be sold to any outside marketing firms and will not be included in any medical studies without the explicit and separate authorization of the patient.

I acknowledge and accept the terms and conditions set forth in Sections II and III of this policy.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**IV. STATEMENT OF FINANCIAL RESPONSIBILITY:** In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor unconditionally guarantees payment in full to Renaissance Women's Healthcare. Renaissance Women's Healthcare agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Renaissance Women's Healthcare understand that Renaissance Women's Healthcare will submit claims for processing. However, the patient! guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.

**V. ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, including Personal Injury Protection or Medical Payment coverage, to pay directly to Renaissance Women's Healthcare proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage.

I acknowledge and accept the terms and conditions set forth in Sections IV and V of this policy statement.

Patient/Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



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### **Insurance Payment Agreement**

I understand Renaissance Women's Healthcare is accepting me as a private pay or commercial insurance patient (not Medicaid) for the dates of service \_\_\_\_\_, and I will be responsible for paying for any services I receive. If I were to qualify for Medicaid the provider will not file a claim for services provided to me.

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

### **Acuerdo de Pago**

Doy por entendido que Renaissance Women's Healthcare me acepta sin seguro medico o con seguro medico (Medicaid no) para los dias \_\_\_\_\_, y yo sere responsable de pagar cualquier servicio que reciba. En caso de que llegue a calificar para Medicaid los doctores no enviaron cobrar a Medicaid por los servicios que se me realizen.

Nombre: \_\_\_\_\_

Firma: \_\_\_\_\_

Fecha: \_\_\_\_\_

Firma autorizada: \_\_\_\_\_



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### **Insurance Responsibility Letter to Patients**

Dear Patient:

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you as the patient, to please check with your insurance company prior to any procedures and/or tests. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs incurred here. Please remember, your insurance policy is between you and your insurance company and not with the insurance company and your doctor.

Sincerely,

Renaissance Women's Healthcare, P.A.

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Patient's Name

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Patient's/Guarantor's Signature

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Date





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**NOTICE OF PRIVACY PRACTICES**

**Patient Acknowledgment**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

The undersigned hereby acknowledges that s/he has received a copy of the Notice of Privacy Practices. Renaissance Women's Healthcare, P.A. will administer our patient records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. A separate authorization must be executed for the non-routine release of Protected Health Information. Patient information shall not be sold to any outside marketing firms, and will not be included in any medical studies without the explicit and separate authorization of the patient.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date