Renaissance Women's Healthcare, P.A.

5115 S. McColl Rd. Edinburg, Texas 78539

OUR PHYSICIANS ONLY PROVIDE SERVICES AT DHR HEALTH WOMEN'S HOSPITAL

Jim Garza, M.D., F.A.C.O.G
Ayda Garza-Montalvo, M.D., F.A.C.O.G.
Rebecca M. Guerra, M.D., F.A.C.O.G.
Kimberly Gonzalez, PA-C

PATIENT REGISTRATION

Patient name: _____ SSN: _____

Date of birth: _____ Age: _____ Marital status: □ Married □ Single □ Divorced □ Widowed □ Minor

Mother/Father/or Legal Guardian if Patient is a Minor: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Cell:(_____) _____

APPOINTMENT REMINDERS: ☐ TEXT ☐ VOICE CALL ☐ E-MAIL

E-mail address (REQUIRED for Patient Portal & Telehealth appointments): _____

Race: _____ (White, Black or African American, Asian, Native Hawaiian, Other). Ethnicity: _____ (Latino/Hispanic, Not Hispanic, Other)

Patient's employer: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Phone No. : (____)_____

Student: ☐ Full-Time ☐ Part-Time Employment status: ☐ Full-Time ☐ Part-Time

If patient is a student, name of school/college: _____

Emergency contact: _____ Phone: (_____) _____ Relation to patient: _____

Referred by: _____

Preferred pharmacy: _____ Address: _____

Do you accept blood transfusions? □ YES □ NO (***If no, please notify Front Desk prior to seeing physician.)***

INSURANCE COVERAGE INFORMATION

Primary insurance name: _____ Phone: (_____) _____

Insured or Policy holder name: _____ SSN: _____

Employer name: _____ Date of birth: _____

ID # _____ Group # _____ Relation to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent

Secondary insurance name: _____ Phone: (_____) _____

Insured or Policy holder name: _____ SSN: _____

Employer name: _____ Date of birth: _____

ID # _____ Group # _____ Relation to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent

The information provided above is true and correct to the best of my knowledge. I understand that no guarantees have been made to me as to the result of such treatments or examinations.

Patient (PARENT If under 18) Signature: _____ Date: _____



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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 (or PARENT IF MINOR) 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 responsible de pagar cualquier servicio que reciba. En caso de que llegue a calificar para Medicaid los doctores no enviaran 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.

_____ _____

Patient's Name Patient's/Guarantor's Signature Date

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5115 S. McColl Rd. Edinburg, Texas 78539
(956) 683-7900 Fax: (956) 683-9910

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MPAS, PA-C

To: _____ DOB:_____
(Patient's Name)

I, _____, own an ownership or
(Doctor's Name)
investment interest in the 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 as required by federal law and the hospital's rules and regulations.

Receipt acknowledged: _____ Date: _____
(Patient's Signature)



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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