ONCOLOGY & HEMATOLOGY OF SOUTH TEXAS, PA

EDUARDO MIRANDA, M.D., FACP

2344 Laguna Del Mar Ct., Suite 104 78041 Laredo, Texas 78045

Phone: (956) 724-8543 Fax: (956) 724-8352

PATIENT INFORMATION

NAME: _____ DOB: _____ SEX: MALE / FEMALE

SOCIAL SECURITY #:_____ MARITAL STATUS: _____

ADDRESS: _____ _____ CITY: _____ __ STATE: _____ ZIP CODE: _____

PHONE #:_____ CELL#:_____ E-MAIL:_____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____WORK PHONE: _____

WHERE IS THE BEST PLACE TO CONTACT YOU? _____ PH# _____ CAN WE LEAVE A MESSAGE: YES / NO

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

PHONE #:_____ CELL #:_____ WORK #:_____

WHO IS YOUR PRIMARY DOCTOR: _____ PHONE #: _____

REFERING PROVIDER'S NAME: _____ PHONE #: _____

PREFERRED HOSPITAL: _____

PREFERRED PHARMACY: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ DOB: _____ SEX: M / F

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY # _____ RELATIONSHIP TO PATIENT: _____

PHONE #: _____ CELL#: _____ EMPLOYER: _____

INSURANCE INFORMATION

ARE YOU COVERED BY HEALTH INSURANCE? _____ IF NO, PLEASE MAKE PAYMENT ARRANGEMENTS WITH OUR BUSSINESS OFFICE.

PRIMARY INSURANCE_____ POLICY **#:_____ GROUP #:_____**
POLICY HOLDER NAME: _____ DOB: _____ SOCIAL SECURITY #:_____
SECONDARY INSURANCE: _____ ____POLICY #: _____ _____ GROUP #: _____
POLICY HOLDER NAME: _____ DOB: _____ SOCIAL SECURITY #:_____

CONSENT FOR PAYMENT

I hereby authorize payment of medical benefits billed to my insurance to Oncology & Hematology of South Texas, PA (OHST, PA). I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if the OHST, PA does not participate with the insurance. I hereby authorize OHST, PA to use and/or disclose my health information which specifically identities me or which can reasonable be used to identify me to carry out my treatment, payment, and healthcare operations.
I understand that while this consent is voluntary, if I refuse to sign this consent, the OHST, PA can refuse to treat me. I understand this authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any actions that the OHST, PA took before receiving my revocation.

Signature of Patient or Patient's Representative: _____ Date: _____

Print Name of Patient: _____ Relationship of Representative to Patient: _____

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REQUEST OF MEDICAL RECORDS FORM

INFORMED CONSENT FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

Name of patient: _____ Date of Birth: _____

I authorize the release of my medical records from the following Doctor and/or facility:

_____

_____

_____

Purpose of release: _____

Specific Reports to be Release (check each one desired):

___A. Physician Progress Notes ___E. Chemotherapy Treatments Reports

___B. Laboratory Reports ___F. Consultation Reports

___C. Pathology Reports ___G. Other (specify):_____

___D. Radiology Reports

Specific Authorization for the release of the following information is given as indicated by patient initials:

___ A. HIV Test Result

___ B. Any Documentation of AIDS Diagnosis

___ C. Psychiatric/Mental Health Treatments Records

I understand that this consent will automatically expire 180 days after the request. This consent is subject to revocation at any time, except that disclosure made prior to the revocation or without knowledge of the revocation is not invalidated. Eduardo Miranda MD., PA, and you personally, are hereby released from legal responsibility or liability for the release of records to the extent indicated and authorized and herein.

Patient Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES
PATIENT CONSENT FOR THE DISCLOSURE OF INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

LIST FAMILY MEMBERS TO WHOM WE MAY DISCLOSE YOUR HEALTH CARE INFORMATION TO:

NAME: PHONE #: RELATIONSHIP WITH PT:

_____

_____

_____

I have read the NOTICE OF PRIVACY PRACTICE and have had any question answered by this office. By signing this form I consent to the following:

The Importance of Protected Health Information (PHI)
Under this law, a person's health information is protected from discriminatory (unfair to the person) or wrongful use or disclosure. Disclosure means to release, transfer, or provide access to protected health information, or to give PHI in any way, to anyone outside the Oncology & Hematology of South Texas, PA.

Examples of discriminatory or wrongful use or disclosure are:
- Insurance companies using protected health information to deny life or disability coverage;
- Employers using protected health information to make decisions about hiring or firing
- Nosy neighbors, family members or reporters using protected health information for their own ends (curiosity or sometimes to make money).

Treatment, Payment, and Health Care Operations (TPO)
Protected health information (PHI) is health information that could reveal the identity of a person. The law allows PHI to be used or disclosed for medical treatment of a person, handling payment activities for the medical services or products the person received, and health care operations (the day to day work of a health care business). These are called TPO uses and disclosures. In most cases, PHI cannot be used or disclosed for non-TPO purposes without getting the person's written permission (authorization).

Security of Electronic Protected Health Information (EPHI)
These security guidelines outline minimum standards for ensuring the confidentiality and integrity of electronic protected health information (EPHI) received, maintained or transmitted by the Oncology & Hematology of South Texas, PA, as well as other offices which support our organization. All Oncology & Hematology of South Texas, PA Department/Entities shall meet or exceed these standards by implementing the necessary administrative, physical and technical safeguards as appropriate based, on their assessments of risk.

Patient's name (PRINT):_____

Signature: _____**Date:** _____

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AUTHORIZATION AND PERMISSION FOR MY PICTURE TO BE TAKEN

I, _____, hereby authorize and give my permission for my picture to be taken for medical records purpose only. I understand that my picture will be seen by all the medical staff and attending physician. My picture /medical records may also be used if I need assistance of any kind including getting medication through a specialty pharmacy.

PATIENT SIGNATURE: _____ Date: _____

PATIENT AUTHORIZATION FOR STUDENT OBSERVATION

Eduardo Miranda, MD, FACP participates in clinical education programs with colleges and universities to give students engaged in a course of study related to a medical career; including medical students, interns and residents ("students") experience in clinical practice. Your physician has agreed to permit such student(s) to observe his/her patient care activities for educational purposes only. The student(s) have signed the proper HIPAA confidentiality agreements and will not be diagnosing or treating but will solely observe your physician during your visit.

By signing below you agree to permit the student(s) at the time they are present in your physician's office to observe your medical care during your visits at this office. You agree that you have been given the opportunity to refuse to give such consent and that you may withdraw your consent at any time during your appointment.

Patient Signature: _____ Date: _____
Patient Name (PRINT): _____

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR COMPLETE THE FOLLOWING:

This patient, whose name is below, is unable to consent to and execute this document for the following reason:
_____

I hereby execute this document on the patient's behalf. I have read and fully understand each part of this document. I represent and verify that I am authorized to execute this document on behalf of the patient named above. I understand that I am entitled to receive a signed copy of this document.

Signature: _____ Date: _____
Printed Name: _____ Relationship to patient: _____
Patient's Name: _____

By signing below I declined to permit the student(s) to observe your medical care during your visits at this office.

Patient Signature: _____ Date: _____

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ADVANCED DIRECTIVES.....DIRECTIVAS AVANZADAS

Name of Patient: _____ Date of Birth: _____

1. **Do you have a living will?** **Yes_____ No_____**
1. **¿Tiene usted un testamento en vida?** **Si_____ No_____**

2. **Do you have a Durable Power of Attorney?** **Yes_____ No_____**
2. **¿Tienes un poder notarial?** **Si_____ No_____**

3. **Do you have a Do Not Resuscitate Form DNR?** **Yes_____ No_____**
3. **Tieneusted una orden "De No Resucitar"?** **Si_____ No_____**

4. **Do you have a surrogate decision maker:** **Yes_____ No_____**
Name of this person: _____Phone_____ Relationship: _____

4. **Tieneustedun sustituto que sea o es responsable para usted:** **Si_____ No_____**
Nombre: _____Telefone:_____ Relacion:_____

Patient's Signature: _____Date_____