Weslaco family care center & OCCUPATIONAL medicine clinic

Patient Information Sheet

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Cell: _____ Work: _____

Where would you prefer us to leave a message? _____

Social Security #: _____ Email: _____

Race: _____ Primary Language: _____ Ethnicity: Hispanic or not Hispanic (circle one)

Insurance Information

Primary Insurance name: _____ Insurance Phone #: _____

Name of Insured: _____ Insured SSN: _____

Group #: _____ Policy #: _____

Co-pay amount: _____

Secondary Insurance name: _____ Insurance Phone #: _____

Name of Insured: _____ Insured SSN: _____

Group #: _____ Policy #: _____

Co-pay amount: _____

Emergency Contact:

Name: _____ Relation to patient: _____

Phone: Home: _____ Cell: _____ Work: _____

Spouse information

Name: _____ DOB: _____ SSN: _____

Driver's License #: _____ Employer Name: _____

Please let our office know if the reason for today's visit is the cause of a WORK INJURY or a MOTOR VEHICLE ACCIDENT.

Financial Responsibility

I understand that professional services rendered are charged to the patient at the time of service. I also understand that all necessary forms must be completed by myself in order for this office to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Weslaco Family Care Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount such as co-payments/ co-insurances and deductibles that are not covered by my insurance.

Authorization to Release Information

I hereby authorize Weslaco Family Care Center to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from Weslaco Family Care Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Retroactive Medicaid

If a patient is not eligible for medical services under Medicaid at the time of service, the patient is considered private pay and is responsible for payment of services. Weslaco Family Care Center does not accept Medicaid for services provided during retroactive eligibility period.

Privacy Notice

I have been presented with a copy of Weslaco Family Care Centers' Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I let the office know in writing of any restrictions concerning the use of my personal medical information.

Consent to Obtain External Prescription History

I authorize Weslaco Family Care Center and its Affiliated Providers to view my external prescription history via the RxHub service
I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescription back in time for several years.
My signature certifies that I read and understood the scope of my consent and that I authorize that access.

Print Patient's Name _____ Date _____

Patient' Signature or Legal Guardian _____ Relation _____
f not signed by the patient, please indicate relationship to patient

nternal Use only
f patient or patient's representative refuses to sign these acknowledgements, please document the date and time these notices were presented.
resented on (date and time) _____
y (name and title) _____