1005 E. Nolana Ave. McAllen, Tx 78504
Ph(956) 686-6510 Fax(956)686-2942

PATIENT INFORMATION
INFORMACIÓN DEL PACIENTE

PROVIDER / *PROVEEDOR* ______________________

PATIENT'S LAST NAME / APELLIDO DEL PACIENTE	FIRST NAME / NOMBRE	MI / IN	DATE OF BIRTH / FECHA DE NAC	SSN / NO SOCIAL	PHONE / TEL	CELLPHONE / CELULAR

PHYSICAL ADDRESS ☐ PERMANENT ☐ TEMPORARY / DOMICILIO PERMANENTE/TEMPORAL	MAILING ADDRESS / DOMICILIO DE CORREO	CITY/STATE / CIUDAD/ESTADO	ZIP CODE / CÓDIGO POSTAL

PATIENT'S EMPLOYER / LUGAR DE TRABAJO	OCCUPATION / OCUPACIÓN	WORK PHONE / TEL NEGOCIO	E-MAIL / E-MAIL

EMPLOYER'S STREET ADDRESS / DIRECCIÓN DEL TRABAJO	CITY, STATE AND ZIP CODE / CIUDAD, ESTADO Y CÓDIGO POSTAL

SPOUSE'S NAME / NOMBRE DE CONYUGE	SPOUSE'S SSN / NO SOCIAL DEL CONYUGE	SPOUSE'S DOB / FECHA DE NAC DEL CONYUGE	SPOUSE'S WORK PHONE / TEL DE TRABAJO DEL CONYUGE

EMERGENCY CONTACT (NAME, PHONE AND RELATIONSHIP)
CONTACTO EN CASO DE EMERGENCIA (NOMBRE, NO. DE TELÉFONO Y RELACIÓN)

IF THE PATIENT IS A MINOR OR STUDENT *SI EL PACIENTE ES MENOR DE EDAD O ESTUDIANTE*

MOTHER'S NAME / NOMBRE DE LA MADRE	MOTHER'S DOB / FECHA DE NAC DE LA MADRE	MOTHER'S SSN / NO SOCIAL DE LA MADRE	FATHER'S NAME / NOMBRE DEL PADRE	FATHER'S DOB / FECHA DE NAC DEL PADRE	FATHER'S SSN / NO SOCIAL DEL PADRE

MOTHER'S EMPLOYER / LUGAR DE TRABAJO DE LA MADRE	MOTHER'S WORK PHONE / TEL NEGOCIO DE LA MADRE	FATHER'S EMPLOYER / LUGAR DE TRABAJO DEL PADRE	FATHER'S WORK PHONE / TEL NEGOCIO DEL PADRE

NAME OF SCHOOL ATTENDING
NOMBRE DE LA ESCUELA QUE ATIENDE

BILLING INFORMATION ALL SERVICES ARE PAYABLE AT TIME RENDERED
SU CUENTA DEBERÁ SER PAGADA AL TIEMPO DE RECIBIR SUS SERVICIOS MÉDICOS

I DO ________ DO NOT ________ HAVE MEDICAL INSURANCE TO COVER SERVICES RENDERED.
YO TENGO ________ NO TENGO ________ SEGURO MÉDICO PARA PAGAR LOS SERVICIOS RECIBIDOS.

____
PATIENT/GUARDIAN SIGNATURE
FIRMA DEL PACIENTE/PADRE

COMPANY NAME / NOMBRE DE LA COMPAÑÍA	POLICY NUMBER / NO. DE PÓLIZA	GRP / GRP

MEDICARE NO. / NO. DE MEDICARE	MEDICAID NO. / NO. DE MEDICAID	IS THERE AN ATTORNEY INVOLVED? ____ YES ____ NO / HAY UN ABOGADO INVOLUCRADO? ____ SI ____ NO	NAME OF ATTORNEY / NOMBRE DEL ABOGADO

MEDICAL HISTORY *HISTORIAL MÉDICO*

FOR WHAT REASON ARE YOU SEEKING TREATMENT:
RAZÓN POR LA CUAL SOLICITA TRATAMIENTO:

DATE OF FIRST SYMPTOMS:
FECHA DE LOS PRIMEROS SÍNTOMAS: ______________________

REFERRAL DR./HOSPITAL:
REFERENCIA DEL DR./HOSPITAL: ______________________

IN YOUR OWN WORDS, DESCRIBE HOW INJURY OCCURRED:
EN SUS PROPIAS PALABRAS, DESCRIBA COMO OCURRIO EL ACCIDENTE: ______________________

____

____

____

ASSIGNMENT OF BENEFIT AND RESPONSIBILITY *ASIGNACIÓN DE BENEFICIOS Y RESPONSABILIDAD*

I REQUEST THAT PAYMENT, IF APPLICABLE UNDER THE MEDICAL INSURANCE PROGRAM DESIGNATED, BE MADE DIRECTLY TO RIO GRANDE VALLEY ORTHOPEDIC CENTER ON CHARGES FOR SERVICES RENDERED FROM: ______________________
YO SOLICITO QUE EL PAGO, SI ES APLICABLE BAJO SEGURO MÉDICO DESIGNADO, SE HAGA DIRECTAMENTE A RIO GRANDE ORTHOPEDIC CENTER SOBRE LA CUENTA POR SERVICIOS RECIBIDOS DE: ______________________

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED DURING MY TREATMENT BY RIO GRANDE VALLEY ORTHOPEDIC CENTER.
YO ENTIENDO QUE SOY RESPONSABLE POR TODOS LOS CARGOS REALIZADOS DURANTE MI TRATAMIENTO CON RIO GRANDE ORTHOPEDIC CENTER.

SIGNED: / FIRMADO: ______________________ DATE: / FECHA: ______________________

VERIFIED BY: / VERIFICADO POR: ______________________ DATE: / FECHA: ______________________

MEDICAL HISTORY
HISTORIAL MÉDICO

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PATIENT'S NAME
NOMBRE DEL PACIENTE

CHART NO.
EXPEDIENTE NO.

	YES/*SI*	NO		YES/*SI*	NO
ARTHRITIS / *ARTRITIS*			PNEUMONIA / *NEUMONÍA*		
OSTEOPOROSIS / *OSTEOPOROSIS*			TUBERCULOSIS / *TUBERCULOSIS*		
RHEUMATISM / *REUMATISMO*			HEART DISORDER / *DESÓRDENES EN CORAZÓN*		
PARALYSIS / *PARÁLISIS*			KIDNEY DISORDER / *DESÓRDENES EN RIÑONES*		
BACK PROBLEMS / *PROBLEMAS DE ESPALDA*			LUNG DISORDER / *DESÓRDENES PULMONARES*		
CANCER / *CÁNCER*			STOMACH DISORDER / *DESÓRDENES ESTOMACALES*		
DIABETES / *DIABETES*			THYROID DISORDER / *DESÓRDENES EN TIROIDES*		
EPILEPSY / *EPILEPSIA*			SURGERIES / *CIRUGÍAS*		
HYPERTENSION / *HIPERTENSIÓN*			ULCERAS / *ÚLCERAS*		

PLEASE EXPLAIN "YES" ANSWERS
FAVOR DE EXPLICAR LOS "SI" ____________________

LIST CURRENT MEDICATIONS
LISTA ACTIVA DE MEDICAMENTOS ____________________

ALLERGIES
ALERGIAS ____________________

DO YOU DRINK ALCOHOL?/*TOMA ALCOHOL?* YES/*SI* NO/*NO* HOW MUCH?/*CUÁNTO?* ________

DO YOU SMOKE?/*FUMA?* YES/*SI* NO/*NO* HOW MUCH?/*CUÁNTO?* ________

DRUG DEPENDENCE/*ADICCIÓN A DROGA?* YES/*SI* NO/*NO*

MARITAL STATUS/ *ESTADO CIVIL* ________ HOW MANY CHILDREN?/ *CUÁNTOS HIJOS TIENE?* ________

PRIMARY CARE DOCTOR/ *DOCTOR FAMILIAR* ________

PREVIOUS INJURIES
LESIONES ANTERIORES:

1. WC / *WC* — DATE OF INJURY / *FECHA DEL ACCIDENTE* ________
2. CAR ACCIENT / *ACCIDENTE DE AUTO* — DATE OF INJURY / *FECHA DEL ACCIDENTE* ________

I HEREBY DECLARE THAT ALL OF THE ABOVE ANSWERS ARE COMPLETE AND TRUE.
YO DECLARO QUE TODAS LAS RESPUESTAS SON COMPLETAS Y VERDADERAS.

SIGNATURE
FIRMA ________ DATE: *FECHA* ________

HIPAA NOTICE OF PRIVACY PRACTICES

1005 E. Nolana Ave. McAllen, Tx 78504
Ph(956) 686-6510 Fax(956)686-2942

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (TPO) AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION, THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OE MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION.

USES AND DISCLOSURES OF HEALTH INFORMATION

YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED BY YOUR PHYSICIAN, OUR OFFICE STAFF AND OTHERS OUTSIDE OF OUR OFFICE THAT ARE INVOLVED IN YOUR CARE AND TREATMENT FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO YOU, TO PAY YOUR HEALTH CARE BILLS, TO SUPPORT THE OPERATION OF THE PHYSICIAN'S PRACTICE, AND ANY OTHER USE REQUIRED BY THE LAW.

TREATMENT: WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR MANAGE YOUR HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO A HOME HEALTH AGENCY THAT PROVIDES CARE FOR YOU. FOR EXAMPLE, YOUR PROTECTED HEALTH INFORMATION MAY BE PROVIDED TO A PHYSICIAN TO WHOM YOU HAVE BEEN REFERRED TO ENSURE THAT THE PHYSICIAN HAS THE NECESSARY INFORMATION TO DIAGNOSE OR TREAT YOU.

PAYMENT: YOUR PROTECTED HEALTH INFORMATION WILL BE USED, AS NEEDED, TO OBTAIN PAYMENT FOR YOUR HEALTH CARE SERVICES. FOR EXAMPLE, OBTAINING APPROVAL FOR A HOSPITAL STAY MAY REQUIRE THAT YOUR RELEVANT PROTECTED HEALTH INFORMATION BE DISCLOSED TO THE HEALTH PLAN TO OBTAIN APPROVAL FOR THE HOSPITAL ADMISSION.

HEALTH CARE OPERATIONS: WE MAY USE OR DISCLOSE, AS-NEEDED, YOUR PROTECTED HEALTH INFORMATION IN ORDER TO SUPPORT THE BUSINESS ACTIVITIES OR YOUR PHYSICIAN'S PRACTICE. THESE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, QUALITY ASSESSMENT ACTIVITIES, EMPLOYEE REVIEW ACTIVITIES, TRAINING OF MEDICAL STUDENTS, LICENSING, MARKETING AND FUND RAISING ACTIVITIES, AND CONDUCTING OR ARRANGING FOR OTHER BUSINESS ACTIVITIES. FOR EXAMPLE, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO MEDICAL SCHOOL STUDENTS THAT SEE PATIENTS AT OUR OFFICE. IN ADDITION, WE MAY USE A SIGN-IN SHEET AT THE REGISTRATION DESK WHERE YOU WILL BE ASKED TO SIGN YOUR NAME AND INDICATE YOUR PHYSICIAN. WE MAY ALSO CALL YOU BY NAME IN THE WAITING ROOM WHEN YOUR PHYSICIAN IS READY TO SEE YOU. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT.

WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LAW, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES: HEALTH OVERSIGHT: ABUSE OR NEGLECT: FOOD AND DRUG ADMINISTRATION REQUIREMENTS: LEGAL PROCEEDINGS: LAW ENFORCEMENT: CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: RESEARCH CRIMINAL ACTIVITY: MILITARY ACTIVITY AND NATIONAL SECURITY: WORKER'S COMPENSATION: INMATES: REQUIRED USES AND DISCLOSURES: UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU AND WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE REQUIREMENTS OF SECTION 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. **YOU MAY REVOKE THIS AUTHORIZATION** AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN AN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH, THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLICANCE OFFICER IN PERSON OR BY PHONE AT OUT MAIN PHONE NUMBER.

SIGNATURE BELOW IS ONLY ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THIS NOTICE OF PRIVACY PRACTICES.

______________________ ______________________ ______________________

(PRINT NAME) (SIGNATURE) (DATE)

PATIENT QUESTIONNARIE

1005 E. Nolana Ave. McAllen, Tx 78504
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PLEASE LIST THE NAME OF YOUR FAMILY MEMBERS OR OTHER PERSONS TO WHOM WE ARE ABLE TO DISCLOSE ANY MEDICAL CONDITION OR TREATMENT WITH:

____

____

____

____

INDICATE IF YOU WANT YOUR CORRESPONDENCE FROM OUR OFFICE TO BE SENT IN A SEALED ENVELOPE:

☐ CONFIDENTIAL ☐ REGULAR MAIL

**** I AM FULLY AWARE THAT CELL PHONE IS NOT A SECURE AND PRIVATE LINE****

PLEASE INDICATE IF WE ARE ABLE TO LEAVE CONFIDENTIAL MESSAGES ON YOUR VOICEMAIL OR ON YOUR ANSWERING MACHINE IF AVAILABLE:

☐ YES ☐ NO ☐ N/A

____________________ ____________________
PATIENT NAME DATE OF BIRTH

____________________ ____________________
PARENT OR GUARDIAN SIGNATURE DATE

REQUEST FOR MEDICAL RECORDS
(PLEASE PRINT)

RGVO
RIO GRANDE VALLEY ORTHOPEDIC CLINIC
1005 E. Nolana Ave. McAllen, Tx 78504
Ph(956) 686-6510 Fax(956)686-2942

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

____
PHYSICIAN'S NAME

____
ADDRESS

____
CITY STATE ZIP CODE

______________________ ______________________
PHONE NUMBER FAX NUMBER

PATIENT NAME: ____

ADDRESS: ____

SSN: ______________ DOB: ______________ PHONE NO.: ______________

______________________ ______________________
SIGNATURE DATE