OSCAR J CERDA, M.D.

FAMILY PRACTICE DOCTOR

To: Oscar J. Cerda, M.D., P.A. From: _____

Fax: (210) 733-3002 Phone: _____

Thank you for choosing Oscar J. Cerda, M.D., P.A. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s)

3). Any and all recent X-rays and MRI's

4). Medications

Office Information:
Oscar J. Cerda M.D., P.A.
5410 Fredericksburg Road, Suite 112
San Antonio, Texas 782229
Ph: (210) 733-3008 Fax: (210) 733-3002

Location:
On Fredericksburg Road
West of Callaghan
In the Legacy Oaks Plaza Buildings

Thank you for choosing Oscar J. Cerda, M.D., P.A. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

OSCAR J CERDA, M.D.
FAMILY PRACTICE DOCTOR

Patient Demographics

Patient Name:_____ Birth Date:_____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-____-____ Cell #: ____-____-____ Work #: ____-____-____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language: _____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: ____-____-____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____ Insured's Name:_____

Policy #:_____ Group #:_____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Company:_____ Insured's Name:_____

Policy #:_____Group #:_____ Insured's Date of Birth: _____

Self-Pay Agreement

I agree to pay for medical services rendered from Oscar J. Cerda, M.D., P.A. I understand that payment must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize OSCAR J. CERDA, M.D., P.A. and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with OSCAR J. CERDA, M.D., P.A. and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of OSCAR J. CERDA, M.D., P.A. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the OSCAR J. CERDA, M.D., P.A. and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

OSCAR J. CERDA, M.D., P.A. and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that OSCAR J. CERDA, M.D., P.A. and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____	_____	_____
Patient Name (Please Print)	Date	Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of OSCAR J. CERDA, M.D., P.A. and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of OSCAR J. CERDA, M.D., P.A. and affiliated providers may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Preferred Pharmacy: _____ **Phone #:** _____

Allergies / Sensitivity to Medications: _____

Chief Complaint for Visit: _____

Current Symptoms: *(Please check all that apply.)*

☐ Headaches	☐ Hoarseness	☐ Bowel Problems
☐ Vision Problems	☐ Throat Problems	☐ Bladder Problems
☐ Nasal Congestion	☐ Swallowing problems	☐ Sexual Difficulties
☐ Runny Nose	☐ Dizziness	☐ Weakness
☐ Ear Problems	☐ Breathing Problems	☐ Numbness
☐ Chest Pain	☐ Stomach Problems	☐ Weight Changes

Past Medical History: *(Please check all that apply.)*

☐ Deafness/Decreased Hearing	☐ Epilepsy / Seizures	☐ Diabetes Mellitus
☐ Heart Problems	☐ Mental Illness	☐ Hemorrhoids
☐ Heart Attack	☐ Nervous Breakdown	☐ Stomach / Bowel Problems
☐ High Blood Pressure	☐ Mental Retardation	☐ Ulcers
☐ Blood Transfusion	☐ Cancer	☐ Migraines
☐ Anemia	☐ Stroke	☐ Arthritis
☐ Bleeding Disorder	☐ Blindness	☐ Hepatitis
☐ High Cholesterol	☐ Glaucoma	☐ Liver Problems
☐ Lung Problems	☐ Sinus Infection	☐ Gout
☐ Asthma	☐ Urine Infection	☐ Broken Bones
☐ Pneumonia	☐ Kidney Disease	☐ Joint Dislocation
☐ Rheumatic Fever	☐ Kidney Stone	☐ Birth Defects
☐ Scarlet Fever	☐ Thyroid Problems	☐ Amputations
☐ Tuberculosis	☐ Venereal Disease	☐ HIV
☐ Allergies		

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Past Surgical History

Operations (Include Biopsy)	Year	Surgeon	Reason for Surgery

Past Hospitalizations *(non-Surgical)*

Hospital	Year	Reason for Admission

Family Medical History: *(Please check all that Apply.)*

Conditions	Father	Mother	Brother(s)	Sister(s)	Children
Diabetes:	☐	☐	☐	☐	☐
High Blood Pressure:	☐	☐	☐	☐	☐
Cancer/Type:	☐	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐
Anemia:	☐	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐

Immunizations:

Description	Last Known Date
PNEUMONIA	/ /
TETANUS	/ /
FLU	/ /
OTHER:	/ /

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Social History:

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Employment: ☐ Employed ☐ Unemployed ☐ Retired Occupation: _____.

Living Situation: ☐ Lives alone ☐ Lives with family ☐ Lives with others

Smoking: ☐ Current Smoker, everyday ☐ Current Smoker, some days ☐ Former Smoker
☐ Never Smoker ☐ _____ packs/day ☐ _____ years smoked

Alcohol Use: ☐ YES ☐ NO
☐ Heavy drinker (1-5 drinks/day) ☐ Moderate Drinker (1-5 drinks/week)
☐ Occasional Drinker

Recreational Drug Use:
☐ YES ☐ NO
☐ Heavy User (daily to weekly) ☐ Moderate User (monthly) ☐ Occasional User

List recreational drugs used: _____.

Periodic Examinations:

(Please Check Exam and State when.)

☐	*Pap Smear:*	/ /	☐	*Mammogram:*	/ /
☐	*Rectal Exam:*	/ /	☐	*Chest X-Ray:*	/ /
☐	*EKG:*	/ /	☐	*Test for Blood in Stool:*	/ /
☐	*Blood Work:*	/ /	☐	*Colonoscopy Exam:*	/ /

FOR WOMEN ONLY:

Last Menstrual Cycle: _____ Method of Birth Control: _____

Number of Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Age of Menopause: _____ Natural or Surgical (Please Circle One)

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____

Current Medications:

List ALL medication that you are currently taking including Non-Prescriptions Medication & Herbal remedies.
(Please DO NOT Substitute a List. Please write meds below)

Medications	Dose	How Often	Approximately Start Date (Month/Year)

OSCAR J CERDA, M.D.
FAMILY PRACTICE DOCTOR

5410 FREDERICKSBURG ROAD, SUITE 112
SAN ANTONIO, TX 782229
PHONE: (210) 733-3008

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to OSCAR J. CERDA, M.D., P.A. and affiliated healthcare providers.

Disclosing Physician / Practice: _____ Phone: (_____) _____-_____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be disclosed to:

OSCAR J. CERDA MD PA
Attn: MEDICAL RECORDS
5410 FREDERICKSBURG ROAD, SUITE 112
SAN ANTONIO, TX 78229
PHONE: (210) 733-3008

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to OSCAR J. CERDA MD, PA.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). OSCAR J. CERDA MD, PA will not condition treatment or payment based upon my signing of this Authorization.
4). The information disclosed by this authorization may be subject to re-disclosure by OSCAR J. CERDA MD PA and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Chris Mathis. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Oscar J Cerda MD PA

Privacy Officer: Chris Mathis

Telephone:210.733.3008 Fax:210.733.3002

E-Mail: not available

Address: 5410 Fredericksburg Road Suite 112 San Antonio, Texas 78229