Patient Information Please Print Clearly

Patient First, Last Name	Social Security #	Sex Male Female	Date of Birth
Address	City	State	Zip
Home Phone	Cell Phone	Alternate Phone	Email

Information Only If Patient is Child/Minor

Mother First, Last Name	Home Phone	Cell Phone	Social Security #
Address (if different)	City	State	Zip
Employer Name	Employer Address	Employer Phone	
Father First, Last Name	Home Phone	Cell Phone	Social Security #
Address(if different)	City	State	Zip
Employer Name	Employer Address	Employer Phone	

Insurance Information

Primary Insurance Company	Customer Service Phone	Policy Holder Name & Date of Birth
Member ID#	Group#	

Secondary Insurance Company	Customer Service Phone	Policy Holder Name & Date of Birth
Member ID#	Group#	

Emergency Contact (other then above)

Name First, Last	Phone	Relationship

As a courtesy, our office will file a claim to your insurance carrier if any is provided. PAYMENT OF THIS BILL REMAINS THE PATIENTS RESPONSIBILITY (GUARDIAN/PARENT IF PATIENT IS CHILD/MINOR).
I authorize all information provided above is correct and accurate. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Harry Hernandez D.O.

Signature	Relationship to Patient	Date

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

Pharmacy Information

- **Pharmacy Name:** _____
- **Address:** _____

  _____
- **Phone:** _____
- **Fax:** _____

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

NOTE REGARDING YOUR MEDICATIONS—

While you are here for your appointment, do not forget to ask to **refill your prescriptions.**

You do not have to call our office for refills unless you are on a narcotic medication, in which case you must be seen on a monthly basis. If you forget to ask the doctor (or physician assistant or nurse practitioner) for your medication while you are here for your appointment, please call your pharmacy first to see if you have any refills left. If you do not have any refills left, you may need to make an appointment; ask the receptionist and/or office staff. You can contact your pharmacy and they can now email the refills you need.

If you have any questions regarding a medication refill, please understand that all telephone calls concerning medication refills are handled at the end of each working day. All calls are handled in the order they are received, and this includes all refill requests.

Respectfully,
Alamo Osteopathic Compliance Officer

****

INFORMACION RESPECTO SUS MEDICAMENTOS—

Mientras está aquí para su cita, no se le olvide pedir que **vuelva a surtir su receta.**

No tiene que llamar a nuestra oficina para recargas de su medicamento al menos que sea medicamento narcótico. Si usted usa medicamento narcótico entonces debe acudir con el médico mensualmente. Si se le olvida pedir su medicamento mientras está aquí para su cita, le puede llamar a la farmacia primero para ver si le quedan algunas recargas. Si no le quedan recargas luego puedo hacer otra cita; pregúntele a la recepcionista u otros asistentes en la oficina. Usted puede contactar su farmacia, la cual puede mandar pedir repuestos por email.

Si usted tiene alguna pregunta relacionada con la recarga de un medicamento favor comprenda que todas llamadas telefónicas sobre recargas se manejan al final de cada día. Además, todas las llamadas se manejan en el orden que son recibidas, así como cualquier solicitud de recarga.

Atentamente,
Oficial de Cumplimiento de Alamo Osteopathic

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

PATIENT INFORMATION

1. You MUST bring all current insurance cards to every office visit.
   a. We can accept temporary Medicaid cards from the DHS office.
2. **All co-pays and deductible are due at the time of service.**
3. There is limited access for post-dated credit card payments—no more than 60 days old.
4. If you have a balance or have signed a payment contract. monthly payments **must be made before you are seen.** If medical attention required is deemed an emergency you will be referred to a local emergency room or community health clinic.
5. **Do not let your medication run out.** Any refill requests will be taken care of within one working week.
6. If you are on **maintenance medication** (i.e. blood pressure medicine, diabetes medicine) you will **need to be seen every three months** unless other arrangements have been made.
7. For all **controlled substance medication, you will need to be seen every month.** No exceptions. A narcotic contract must also be signed.

Patient Signature: _____

Date: _____

****

INFORMACION PARA EL PACIENTE

1. Se REQUIERE que traiga su credencial de su seguro en CADA VISITA.
   a. Podemos aceptar credenciales temporarias de Medicaid, las cuales son de la oficina de DHS.
2. **Todos co-pays y deducibles se tienen que pagar el mismo día que recibe servicio.**
3. Hay acceso limitado para pagares con tarjeta de crédito con fecha diferente a la fecha del servicio recibido. No pueden ser más de 60 días.
4. Si tiene un balance o si ha firmado un contrato de pagares, los pagos mensuales **se tienen que recibir antes de recibir servicio.** Si la atención médica que Ud. requiere es urgente será referido a un lugar de Urgencias o a un hospital local.
5. **No deje que se le acabe su medicamento.** Cuando necesite volver a surtir su medicamento lo haremos dentro de una semana cuando Ud. lo pida.
6. Si usted toma medicamento de rutina (por ejemplo para alta presión o para diabetes) tiene que acudir para una cita médica **cada tres meses** al menos que Ud. haga otro acuerdo con su médico.
7. **Para todo medicamento que es sustancia controlada, tiene que acudir a una cita médica cada mes.** No hay excepciones. Además, un acuerdo de narcóticos tiene que ser firmado.

Firma del paciente: _____

Fecha: _____

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Alamo Osteopathic Physicians & Surgeons.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
Witness Signature	Date

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ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

GENERAL CONSENT AND DISCLOSURE

The information in this consent form is given so you will be better informed about the health care services you will receive. After you are sure you understand the information that will be given about the services provided by Alamo Osteopathic Physicians and Surgeons, please sign below.

GENERAL CONSENT

I give consent to the Doctor, his designated staff, and other medical personnel providing services under the Doctor, who has sponsorship to perform a physical assessment or examination, conduct laboratory or other tests, give injections, medication, and other treatment, and render other health services to the patient identified on this form.

STORAGE OF MEDICAL RECORDS

I understand that my medical records will be stored securely.

INFORMED CONSENT

In addition to the above general consent, I understand that special informed consent forms must be read and signed for any specific procedure to be done.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Doctor to furnish such professional information as may be necessary for the completion of my patient care insurance claims by the health insurance carriers, from the medical records compiled during my present visit and hereby release said facility from all legal liability that may arise from the information requested.

AUTHORIZATION OF INSURANCE BENEFITS

In consideration of services rendered, I hereby irrevocably assign the transfer to the Doctor all rights, title, and interest of all benefits payable to me for the services described herein as provided in the mentioned policy and policies of insurance. I agree to pay at the office the charges which exceed the amount paid by the named insurance company. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. The undersigned further assigns all right to payment due for medical and/or surgical service(s) under said policies to the attending physicians, radiologist, pathologist, etc.

QUESTIONS

I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have about the services have been answered to my satisfaction.

Do you have an Advanced Directive (Living Will) or Durable Power of Attorney?
Yes _____ No _____

Do you want more information regarding Advanced Directive?
Yes _____ No _____

Patient Printed Name: _____

Patient Signature: _____

Person authorized to consent and relationship to patient(print): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and 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 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 or mental health or condition and related health care services.

Uses and Disclosures of Protected 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 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 to 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.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, 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, including: 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, Organ Donation, Research, Criminal Activity, Military Activity, 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.

Continued on back.....

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

Your Rights: Following is a statement of your rights with respect to your protected health information.

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
    a. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
4. **You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
5. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before April 14, 2003.

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 Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name; _____

Signature: _____

Date: _____

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

PATIENT INFORMATION / INFORMACION SOBRE EL PACIENTE

Patient Name (Nombre): _____

Please select the correct response (Favor de seleccionar la respuesta adecuada):

Race (Raza): 1- American Indian or Alaska Native (Indio Americano o Nativo de Alaska)

2- Asian (Asiático)

3- Black or African-American (Negro o Africano-Americano)

4- White (Blanco)

5- Hispanic (Hispano)

6- Native Hawaiian or other Pacific Islander (Hawaiano Nativo u otro Nativo de las Islas Pacificas)

7- Other (Otro)

Ethinicity (Ethnicidad): 1- Hispanic (Hispano)

2- Non-Hispanic (No Hispano)

3- Unknown (Desconocido)

Language (Idioma): _____

ALAMO OSTEOPATHIC PHYSICIANS AND SURGEONS

PAST, FAMILY, AND SOCIAL HISTORY

Patient name:_____ Age:_____ Date:_____

MEDICINES TAKEN REGULARLY **REASON**

_____

_____

_____

_____

_____

PERSONAL PAST HISTORY

Have you ever had?			Year	Operations		Year
Measles	yes	no		Tonsil	yes no	
Mumps	yes	no		Appendix	yes no	
Whooping cough	yes	no		Gallbladder	yes no	
Polio	yes	no		Stomach	yes no	
Diphtheria	yes	no		Breast	yes no	
Meningitis	yes	no		Uterus, ovary	yes no	
Valley fever	yes	no		Prostate	yes no	
Malaria	yes	no		Hernia	yes no	
Hives	yes	no		Thyroid	yes no	
Cancer	yes	no		Varicose veins	yes no	
Venereal Disease	yes	no		Hemorrhoids	yes no	
Arthritis	yes	no		Hip	yes no	
Rheumatic fever	yes	no		Knee	yes no	
Heart Failure	yes	no		Other_____		
Blood transfusions	yes	no		_____		
Hepatitis	yes	no		_____		
Kidney disease	yes	no		_____		
Hay fever	yes	no		**INJURIES**		**YEAR**
Glaucoma	yes	no		Head	yes no	
Thyroid Disease	yes	no		Chest	yes no	
Other_____				Abdomen	yes no	
_____				Broken bones	yes no	
_____				Back	yes no	
_____				other		

ALLERGIES		**YEAR**	**IMMUNIZATION**		**YEAR**
Tetanus	yes no		Influenza	yes no	
Penicillin	yes no		Pneumococca	yes no	
Sulfa	yes no		Tetanus	yes no	
Other_____			Hepatitis B	yes no	
_____			**OB/GYN**		**YEAR**
_____			Pregnancies	#	
_____			Miscarriages	#	
_____			Abortions	#	
_____			First period:		
			Last period:		

SOCIAL HISTORY#1

Birth Place: Birth Date:

Religion: Marital Status

Occupation:

Do you have a "Living Will", Advanced Directive, or Surrogate Decision Letter?

yes no

FAMILY HISTORY

Have you or any blood relative had any of the following:

	Relationship		Practitioner 's Notes
Anemia	yes	no	
Bleeding tendency	yes	no	
Repeated infections	yes	no	
Heart attack/Angina	yes	no	
Chronic lung disease	yes	no	
Tuberculosis	yes	no	
High blood pressure	yes	no	
Asthma	yes	no	
Severe allergies	yes	no	
Mental/emotional illness	yes	no	
Seizures	yes	no	
Migraine headaches	yes	no	
Diabetes	yes	no	
Gout	yes	no	
Obesity	yes	no	
Ulcer	yes	no	
Chronic diarrhea	yes	no	
Cancer/Leukemia	yes	no	
Alcohol/Drug problem	yes	no	
Family violence/abuse	yes	no	

Present age, and is general health good or poor?

If deceased, age at death and cause of death?

Father_____

Mother_____

Brother(s)_____

_____

Sister(s)_____

_____

Spouse_____

Children_____

_____

SOCIAL HISTORY #2

In an average week I exercise or work vigorously: _____hour

My compliance with healthy diet is:

poor fair good excellent

My religious faith is:

none average important vital

My sexual orientation is:

heterosexual homosexual(gay/lesbian bisexual transgender

AVERAGE PER DAY OR WEEK (specify)

Alcohol- type_____

Tobacco- type_____

Tea or coffee- type_____

Other- type_____

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Date: _____ DOB: _____ Last 4 of SSN: _____

SECTION I: I, the undersigned patient, hereby authorize the use of disclosure of information from my medical record. I authorize the following individual or organization to disclose the above-named individual's health information:

_____

Telephone Number: _____ Fax Number: _____

This information may be disclosed/released to and used by Alamo Osteopathic Physicians & Surgeons for the following purpose: at the request of the individual; or continuity of care.

Please release the following records:

_____ History & Physical Exam	_____ X-ray/Imaging Result(s)	_____ Problem List
_____ Laboratory Result(s)	_____ Progress Notes	_____ EKG reports
_____ Medication List	_____ Immunization Record	

_____ _____

Signature of Patient/Legal Representative **Date**

SECTION II: I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

_____ **Yes, I consent** _____ **No, I do NOT consent**

SECTION III: ***Complete the following **ONLY** if information is to be released directly to the patient.***

I understand that my medical record may contain reports, rest results, and notes that only a physician can interpret. I understand and have been advised that I should contact a physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Alamo Osteopathic Physicians & Surgeons liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient/Legal Representative **Date**

****

For office use only: Date request completed: _____ Number of pages copied: _____

Charges: $_____ (CASH / CHECK / CREDIT CARD)

1339 Fair Ave
SA, TX 78223
(210) 533-3864
Fax 534-8444

12650 Nacogdoches
SA, TX 78217
(210) 656-4363
Fax 599-1251

9418 Guilbeau
SA, TX 78250
(210) 798-7765
Fax 798-7767

5975 FM 78, Ste 300
SA, TX 78244
(210) 662-0076
Fax 662-0788

900 Oblate
SA, TX 78216
(210) 314-4055
Fax 396-7021

705 W. Kirk Pl
SA, TX 78226
(210) 225-2200
Fax 225-1630

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

COVID-19 SCREENING QUESTIONNAIRE

The safety of our patients and staff is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our patients and staff, we are asking everyone to complete and submit this questionnaire.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our employees.

Patient Name:
Date of Birth:
Accompanying Guest Name (if you have one):

	Representations
1.	Are you **currently experiencing**, or have you experienced **in the past week**, any of the Following symptoms? **Yes** ☐ **No** ☐ Fever (100.4° F/37.8° C or greater as measured by an oral thermometer) **Yes** ☐ **No** ☐ Cough **Yes** ☐ **No** ☐ Shortness of Breath or Difficulty Breathing **Yes** ☐ **No** ☐ Sore Throat **Yes** ☐ **No** ☐ New Loss of Taste or Smell **Yes** ☐ **No** ☐ Chills **Yes** ☐ **No** ☐ Headaches or Muscle Aches **Yes** ☐ **No** ☐ Nausea, Diarrhea, Vomiting
2.	**In the past week,** have you been in close proximity to anyone who is experiencing any of the above symptoms or has experienced any of the above symptoms since your last contact? **Yes** ☐ **No** ☐
3.	**In the past week,** have you been in close proximity to anyone who has tested positive for COVID-19? **Yes** ☐ **No** ☐
4.	**In the past week,** have you been tested for COVID-19 and are waiting to receive test results? **Yes** ☐ **No**☐
	TURN OVER TO COMPLETE BACK SIDE

ALAMO OSTEOPATHIC

PHYSICIANS AND SURGEONS

5.	**In the past week,** Have you have recently tested **positive** for COVID-19, or are you **currently presumptively positive** for COVID-19 based on your health care provider's assessment or your symptoms? **Yes ☐ No ☐**
6.	**In the past week,** have you been on a commercial flight or traveled outside of the United States? **Yes ☐ No ☐**
7.	**In the past week,** have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? **Yes ☐ No ☐**

Certification

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____ **Date:** _____

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to your manager or your human resources representative.