Cigarroa CLINIC

Patient Intake Form

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Birth: _____ Sex: Male ☐ Female☐ Non-binary ☐ Other☐ _____
Social Security #: _____ Address: _____
City and State: _____ Zip code: _____ Marital Status: M ☐ S ☐ W ☐ D ☐
Phone Number: (_____) _____ Alt Number: (_____) _____
Email Address: _____ Employment Status: Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Prefer Not to Answer ☐
Place of Employment: _____ Work Number: (_____) _____

Emergency Contact

Name: _____ Relationship: _____
Phone Number: (_____) _____ Alt Number: (_____) _____
Name: _____ Relationship: _____
Phone Number: (_____) _____ Alt Number: (_____) _____

Referrals and Adjunctive Care

Are you currently under medical care? ☐ Yes ☐ No For? _____
Primary Care Physician (PCP): _____
Do you see any other specialist/physician? _____
Any Adjunctive Care services? ☐ Home Health ☐ Palliative ☐ Hospice ☐ Nursing Home/Assisted Living Facility ☐ Dialysis ☐ Rehab ☐ Mental Health Services ☐ Other (specify: _____)
How did you hear about us? _____
What is your reason for seeing us today? _____

Insurance Information – Please present your current insurance card at the time of your visit for verification purposes

Insurance Company Name: _____ Are you the policy holder? ☐ Yes ☐ No
Policy Holder's Full Name: _____ DOB: _____
Relationship to patient: ☐ Self ☐ _____ Holder's ID/DL Number: _____
Insurance Group Number: _____ Policy Number: _____
Insurance Contact Number: (_____) _____ Type of Plan: ☐ HMO ☐ PPO ☐ EPO ☐ _____

Do you have a secondary insurance? ☐ Yes ☐ No
Insurance Company Name: _____ Are you the policy holder? ☐ Yes ☐ No
Policy Holder's Full Name: _____ DOB: _____
Relationship to patient: ☐ Self ☐ _____ Holder's ID/DL Number: _____
Insurance Group Number: _____ Policy Number: _____
Insurance Contact Number: (_____) _____ Type of Plan: ☐ HMO ☐ PPO ☐ EPO ☐ _____

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Authorization for release of information and payment – Payment Policy

☐ I authorize Cigarroa Clinic to release information to my insurer and direct payments for medical benefits to the clinic. I acknowledge my responsibility for any charges not covered by insurance. I understand that claim resolution is not the clinic's responsibility, and separate fees apply for radiologist interpretations with imaging procedures.

Authorization for Communication Methods

☐ I authorize Cigarroa Clinic (Laredo Cardiovascular Consultants, P.A.) to contact me via phone calls, voicemails, **text messages**, and **emails** for purposes related to my medical care. This may include appointment reminders, follow-up questions, and other healthcare-related information. I understand that these communications will be conducted in a manner compliant with HIPAA regulations to ensure the confidentiality and security of my personal health information.

Preferred Contact Information:

- Phone Number: _____
- Email Address: _____

Acknowledgement of Receipt of Privacy Notice

☐ I have been presented with a copy of Cigarroa Clinic's (Laredo Cardiovascular Consultants, P.A.) Webb County Notice of Privacy Policies detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the notice and I requested the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignments. Regulations permitting to medical task of benefits apply.

Signed: _____ Date: _____

Relationship: _____ Witness: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse/authorized representative)

- -

Internal Use Only

If patient or patient's representatives refuses to sign Acknowledgment of Receipt of Notice, please document the date and time the notice was presented to patient and sign below.

Name & Title: _____ Date: _____

1710 E. Saunders St., Medical Tower B, 5th Floor, Laredo TX 78041
P.O. Box 2649 • Laredo, TX 78044-2649 • (956) 725-1228 • Fax: (956) 725-0833

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DISCLOSURE OF OWNERSHIP AND ALTERNATIVE PROVIDERS OF DIAGNOSTIC TESTING

Date: _____

I, _____, fully understand that all medical equipment used in this facility is owned solely by Cigarroa Clinic (Laredo Cardiovascular Consultants, PA). I have reviewed a list of alternative providers/facilities of diagnostic testing.

Alternative Facilities:

Community Health Systems
1700 E Saunders St
Laredo, TX 78041
956-796-5000 (No PET services provided at this facility)

University Health Services
10700 McPherson Rd
Laredo, TX 78045
956-523-2000 (No PET services provided at this facility)

Radiology Clinic of Laredo
5401 Springfield Ave
Laredo, TX 78041
956-718-0092 (No PET or Nuclear Medicine Services provided at this facility)

Laredo Premier ASAS Health
7215 McPherson Rd.
Laredo, TX 78041
956-608-4500 (No PET, CT, or Nuclear Medicine Services provided at this facility)

Metabolic Imaging of Laredo
2344 Laguna Del Mar Ct,
Laredo, TX 78041
956-725-6400 (No Nuclear Medicine, CT, Radiography or Ultrasound Services provided at this facility)

Laredo Vascular and Ultrasound Center
5702 McPherson Rd.
Laredo, TX 78041
956-723-2220 (No PET, CT, Radiography or Nuclear Medicine Services provided at this facility)

Carlos G. Cigarroa, M.D, PA
702 E. Calton Rd. Suite #101
Laredo, TX 78041 (No PET, CT, Radiography or Ultrasound Services provided at this facility)

Cigarroa CLINIC

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

Patient Name: _____ Date of Birth: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including, but not limited to:

- ☐ All medical records (every page in my record, including office notes, consultations, treatment records, clinical charts, nurse's notes, etc.)
- ☐ All physical, occupational and rehab requests, consultations and progress notes.
- ☐ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- ☐ All employment, personnel or wage records.
- ☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens, radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram, nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- ☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- ☐ All billing records including all statements, insurance claim forms, itemized bills and records of billing to third party payers and payment or denial of benefits for the period of _____ to _____.

Methods of Disclosure:

- ☐ I consent to the disclosure of my health information through the following methods as may be necessary: in writing, photocopy, paper, electronic, verbal, and fax communication.

This information may include data relating to sexually transmitted diseases, AIDS/HIV, and alcohol/drug abuse treatment. This authorization is given in compliance with federal consent requirements for the release of alcohol or substance abuse records under 42 CFR 2.31. This protected health information is disclosed for the purpose of continuing medical care with Cigarroa Clinic.

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You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Name of Representative

_____
Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____
Street Address

_____
City, State and Zip Code

I understand the following (see CFR § 164.508 (c) (2) (i-iii)):

a. I have the right to revoke this authorization at any time except where action has already been taken based on this authorization.
b. Information released may be subject to re-disclosure by the recipient and may no longer be protected.
c. My treatment or payment for treatment cannot be conditioned on signing this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires:

_____ _____
Signature of Patient or Legally Authorized Representative *(see 45CFR § 164.508 (c) (1) (vi))* Date

_____
Name and Relationship of Legally Authorized Representative to Patient *(see 45CFR § 164.508 (c) (1) (iv))*

_____ _____
Witness Signature Date

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Cigarroa Clinic Telemedicine Consent

Patient Name: _____ **DOB:** _____

1. **Nature of Telemedicine Consultation**: I understand that a telemedicine consultation involves the use of electronic communications to enable healthcare providers at Laredo Cardiovascular Consultants, P.A., doing business as Cigarroa Clinic, to deliver services to me at a location remote from the provider. I understand that I will not have a direct physical examination by the provider during a telemedicine consultation, which in some cases may affect the provider's ability to diagnose and treat my condition.
2. **Medical Information and Records**: I understand that all existing laws regarding access to my medical information and copies of my medical records apply to telemedicine. As such, I will have access to all information resulting from the telemedicine service as provided by law for access to my medical records.
3. **Confidentiality**: I understand that the laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential.
4. **Risks and Benefits**: I understand that there are risks from telemedicine, including but not limited to, the possibility that the transmission of my medical information could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons. However, I also understand that telemedicine offers benefits including easier access to care, the ability to receive treatment when unable to present for an in-person visit, and the continuity of care.
5. **Rights**: I understand that I have the right to withhold or withdraw my consent to the use of telemedicine services at any time without affecting my right to future care or treatment.
6. **Questions and Concerns**: I have had the opportunity to ask questions about the nature and risks of telemedicine, and my questions have been answered to my satisfaction. I understand the procedures and any possible risks involved with telemedicine services.
7. **Billing and Payments**: I understand that billing for telemedicine services will be similar to billing for an in-person healthcare service. I may be responsible for any copayments or deductibles that apply to my telemedicine visit.
8. **Follow-up Care:** If I require follow-up care or have an emergency, I can reach out to Cigarroa Clinic at the contact information provided below. In case of an emergency, I will dial 911 or go to an emergency room.
9. **Technical Requirements:** I understand that I am responsible for the necessary technology requirements to participate in telemedicine services, including access to a reliable internet connection and a computer or mobile device with a camera and microphone.
10. **Patient Consent:** I have read and understand the information provided above. I have discussed it with my healthcare provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

_____ _____

Patient/Authorized Representative Signature Date

_____

Relationship to Patient

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