Carolina Praderio, M.D.

Gynecology

Dr. Carolina Praderio, M.D.

New Patient Information

Date: ________________, 20____

Last Name: ________________________ First:_____________________ SS#:_________________

Address: ____

City: _______________________________ State:_____________ Zip Code: _________________

Home Phone #:________________________ Work #:_____________________________

Cell Phone #:__________________________ Occupation: _________________________________

Date of Birth: ____/_____/_______ Employer: ____
(mm/dd/yyyy)

Marital Status: _________________ Spouse Name: ____

Spouse Date of Birth: ____/_____/_______ Spouse SS#:________________________________
(mm/dd/yyyy)

Spouse Employer: ___________________________ Work Phone #:__________________________

Emergency Contact (other than spouse): ____

Emergency Contact Phone #:____

Primary Physician: ____

Preferred Pharmacy & Phone #:____

♦♦

Primary Insurance: ____

Id Number: ______________________________ Group Name/Number: ___________________________

Insured Name: ____

Secondary Insurance: ____

Id Number: ______________________________ Group Name/Number: ____________________________

Insured Name: ____

♦♦

PAYMENT FOR OFFICE SERVICE IS DUE ON THE DAY OF THE VISIT. PAYMENT MAY BE MADE BY CHECK, CASH, OR VISA/MASTERCARD. AN ITEMIZED COPY OF THE SERVICES PROVIDED IS AVAILABLE TO YOU FOR THE INSURANCE PURPOSES.

PATIENT/PHYSICIAN AGREEMENT: I, the undersigned, authorize Carolina Praderio, MD, PLLC to release any information required in the course of me examination or treatment to my insurance company(s) or another physician. I recognize that the medical insurance I possess may not completely cover fee(s) for professional services rendered to me. I hereby assign payment directly to the physician for all medical services to my dependents or me. I understand that I am responsible for charges not covered by any insurance company.

Signature: ___________________________________ Date: _____/_____/________
(mm/dd/yyyy)

If minor, please Complete:

Parent or Guardian: _______________________________ Relationship: ______________________________

Address: ____

City:________________ State:_______ Zip:_____________ Phone:___________

NEW PATIENT HEALTH INFORMATION

Name: _____ DOB: (mm/dd/yyyy) ____/____/_____

Reason for Visit: _____

Medications & Supplements:

_____

_____

_____

_____

Allergies:

_____

_____

_____

Alcohol Use: YES NO Smoker: YES NO Drug Use: YES NO

Caffeine Use: YES NO If yes, how much: _____

Gynecological History:

of Pregnancies: _____ # of Deliveries: _____

LMP: (mm/dd/yyyy) ____/____/_____ Last PAP: (mm/dd/yyyy) ____/____/_____

Last Colonoscopy: (mm/dd/yyyy) ____/____/_____

Last MMG: (mm/dd/yyyy) ____/____/_____ Last Bone Density/DEXA Scan: (mm/dd/yyyy) ____/____/_____

Surgeries:

_____

_____

_____

_____

Patient History:

Heart Disease: YES NO Respiratory: YES NO Anemia: YES NO

Thyroid Problems: YES NO Diabetes: YES NO Hypertension: YES NO

Cancer: YES NO Other:_____

PLEASE COMPLETE THIS FORM AND BRING TO THE OFFICE ON THE DAY OF YOUR APPOINTMENT.

Carolina Praderio, M.D.
Gynecology

Dr. Carolina Praderio, M.D.

ACKNOWLEDGEMENT OF RECIEPT
PRIVACY PRACTICES NOTIFICATION

I acknowledge that I have received and had an opportunity to read the privacy practices of the office of Carolina Praderio, MD. In reading this information, I understand my rights as a patient. I also understand that uses and disclosures may be permitted without prior consent in the event of an emergency.

If it is necessary for Dr. Carolina Praderio or her staff to notify me of personal health information, I wish to be contacted in the following manner. (Check all that apply):

☒ Home Telephone ________________________
☐ OK to leave message with detailed information
☐ Leave message with call-message number only
☐ OK to fax to this number: ____________________

☐ Written Communication
☐ OK to mail to my home address
☐ OK to mail to my work address

☐ Work Telephone __________________
☐ OK to leave message with detailed information
☐ Leave message with call-back number only

☐ Cellular Phone _______________
☐ OK to leave message on voicemail
☐ Leave message with call-back number only

☐ E-mail:____

☐ Personal health or financial information may be released to the following people (i.e-spouse):

____

♦♦♦

***Note: In the event that patient is compromised, it may be necessary for Dr. Carolina Praderio or her staff to communicate with a patient via certified mail without the patient's consent.

__________________________   ____/____/______________

Patient Signature   Date (mm/dd/yyyy)

__________________________   ____/____/______________

Print Name   Date of Birth (mm/dd/yyyy)

ATTENTION PATIENTS

Notice Regarding your Insurance Coverage for Services Rendered

Dear Patient:
Currently, you are being seen in our office for your medical care. Please understand that as a preferred provider, we contracted with a large number of insurance companies and always try to comply with their requirements for laboratory testing, mammograms, x-rays, hospitalizations and outside physician referrals.

However, with many different insurance policies available and ever-changing contractual agreements between those companies and their policyholders, it becomes impossible to ascertain where your insurance policy is accepted as a preferred provider.

THEREFORE, IT IS IMPORTANT THAT YOU, THE PATIENT, UNDERSTAND YOUR OWN INSURANCE POLICY AND BE FAMILIAR WITH FACILITIES YOUR INSURANCE REQUIRES.

Remember that the insurance is purchased by you individually or by your employer on your behalf. Keep in mind the contractual agreement between you and your insurance company. Therefore, to avoid any misunderstandings regarding coverage at any location, please refer to your insurance policy or call your insurance company if any services outside our office are required.

Thank you for choosing us as your healthcare provider.

With Kindest Regards,
Carolina Praderio, MD, PLLC

_____ _____/____/_____

Patient Signature: **Date:** (mm/dd/yyyy)

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize my health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Carolina Praderio, MD
Address: 5920 Saratoga Blvd Corpus Christi, TX 78414
Phone: (361) 991-9356
Fax: (844) 717-5672

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including:
- ❑ Labs/Pathology
- ❑ Imaging
- ❑ Surgeries/Operative Notes
- ❑ Office Visits

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20_____.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

_____	____/__/____	_____
Signature	Date	Signature of Witness
_____	____/__/____	
Print Name:	Date of Birth (mm/dd/yyyy)	

If individual is unable to sign this Authorization, please complete the information below:

_____	_____	____/__/____	_____
Name of Guardian	Legal Relationship	Date (mm/dd/yyyy)	Witness

Carolina Praderio MD, FACOG
Gynecology
5920 Saratoga Blvd. Ste. 110
Corpus Christi, TX 78414
361-991-9356

NO-SHOW/LATE CANCELLATION POLICY

To help us serve you better, this policy will become effective April 22, 2015.

_____ Late Cancellation of Office Visit

Initials

Regular business hours are **Monday-Thursday 8:00 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 12:00 p.m.**

_____ Phone calls during regular business hours

Initials

- During regular business hours, patients are encouraged to call the office with medical questions and refill requests.

_____ Emergency Phone calls outside of regular business hours

Initials

- Dr. Praderio is available after hours for **EMERGENCY PHONE CALLS ONLY.**
- **An example of an emergency is EXCESSIVE BLEEDING (Soaking a pad in less than 1 hour)**
- If you have an emergency **DO NOT** call to let Dr. Praderio you are going to the emergency room, the doctor in the ER will inform Dr. Praderio.
- Prescription refills are **NOT an emergency** and they will not be called in. We ask that you wait until regular business hours for your request

_____ NON-Emergency Phone calls outside of regular business hours

Initials

- NON-Emergency phone calls take time away from actual emergencies.
- **Some examples of non-emergencies are:**
  - Difficulty sleeping
  - Constipation
  - Cold Symptoms
  - Indigestion
  - Yeast Infections
  - Urinary Tract Infections
- Any patient calling after regular business hours **with non-emergency issues will be charged a fee of $25.**

I have read and understand Dr. Carolina Praderio's After Hours Phone Call Policy. I understand that I will be charged for non-emergency phone calls made after hours.

_____ _____

Patient Signature **Date**

Carolina Praderio MD, FACOG
Gynecology
5920 Saratoga Blvd. Ste. 110
Corpus Christi, TX 78414
361-991-9356

NO-SHOW/LATE CANCELLATION POLICY

To help us serve you better, this policy will become effective April 22, 2015.

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide **at least 24 hours' notice**. This enables us to schedule another patient who is waiting for an appointment with Dr. Praderio. When cancellations are made less than 24 hours in advance, we are unable to offer that appointment slot other patients.

_____ Late Arrivals

Initials

- We understand that life happens. We can be flexible. If you are running late, please call our office and let the staff know you are on your way.
- Patients who arrive **more than 15 minutes after their scheduled appointment will be cancelled and may be assessed a $25 cancellation fee.**

_____ Cancellations of Office Visits

Initials

- Patients are asked to reschedule or cancel their appointment at least **24 hours in advance**.
- **Appointments cancelled with less than 24 hours' notice may be subject to a $25 cancellation fee.**

_____ Cancellation of Surgery

Initials

- Surgery cancelations require **AT LEAST 24 hours' notice BEFORE YOUR SCHEDULED PRE-OP.** Pre-Op usually occurs 5-7 days BEFORE your scheduled surgery.
- **Failure to provide at-least 24 hours' notice BEFORE your scheduled Pre-Op will result in a $50 cancellation fee.**

_____ Repeated "No-Show"

Initials

- A "No-Show" is when a patient fails to arrive for a scheduled appointment without advance notice to the physician or the physician's office.
- **Patients who "No-Show" three times or more may be dismissed as a patient from the practice and will be denied any future appointments.**

I have read and understand Dr. Carolina Praderio's No-Show/Late Cancellation Policy. I understand that I will be charged for cancellation fees and that 3 "No-Shows" will result in my dismissal as a patient.

_____ _____

Patient Signature **Date**