

Carolina Praderio MD, FACOG
Gynecology
5826 Esplanade Dr. Suite 101
Corpus Christi, TX 78414
361-991-9356

New Patient Information

Date: _____

Last Name: _____ First Name: _____ SS#: _____

Address: _____
Street City State Zip

Phone: (Home) _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____

Primary Physician: _____ Primary Physician Phone: _____

Married? Y N (Skip this section if NO)

Spouse Name: _____ Spouse DOB: _____ Spouse SS#: _____

Spouse Employer: _____ Spouse Employer Phone: _____

Emergency Contact (other than spouse): _____ Phone: _____

Primary Insurance Information

Primary Insured Name: _____ Member ID #: _____

Insurance Provider Name: _____ Group #: _____

Secondary Insurance Information

Secondary Insured Name: _____ Member ID #: _____

Insurance Provider Name: _____ Group #: _____

Payment or Co-payment for office service is due on the day of the visit. Payment may be made by check, cash or credit card. An itemized copy of the services provided is available to you for insurance purposes.

Patient/Physician Agreement: I, the undersigned authorize Dr. Carolina Praderio M.D., PLLC to release any information required in the course of my examination or treatment to my insurance company(ies). 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 to me. I understand that I am responsible for charges not covered by any insurance company.

Signature: _____ Printed Name: _____ Date: _____

If minor, please complete: Parent or Guardian: _____ Relationship: _____

Address: _____
Street City State Zip



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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 are 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: _____

Printed Name: _____

Patient Date of Birth: _____

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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
 Ok to leave message with call-back information ONLY

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
 Ok to leave message with call-back information ONLY

Cell Phone: _____

- Ok to leave message with detailed information
 Ok to leave message with call-back information ONLY
 Ok to text

OK to fax to this number: _____

Fax Number

OK to E-Mail: _____

E-mail Address

OK to release personal health information to the following person/people:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

***NOTE: in the very unlikely event that the patient information 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: _____

Printed Name: _____

Patient Date of Birth: _____

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New Patient Health Information

Date: _____

Last Name: _____ First Name: _____ SS#: _____

Reason for visit: _____

Current medications & supplements you are taking or have taken in the last 6 weeks:

Medication or Supplement Name	Date Last Taken
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Please list any allergies:

Alcohol Use? Y N Smoker? Y N Caffeine Use? Y N

Drug Use? Y N If yes, please list which drugs: _____

Gynecological History:

of Pregnancies: _____ # of Deliveries: _____ Last Menstrual Period: _____

Last Pap: _____ Last Colonoscopy: _____ Last MMG: _____


Last Bone Density /DEXA Scan: _____

Please list all previous Surgeries: _____

Medical History (Check all that apply):

Heart Disease Respiratory Disease Anemia Thyroid Problems Diabetes Hypertension

Cancer Other: _____


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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.

Signature: _____ Printed Name: _____ Date: _____

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Authorization for Use/Disclosure of Health Information

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

Name (First, Last)

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

Name: Carolina Praderio, MD

Address: 5826 Esplanade Dr. Corpus Christi, TX 78414

Phone: (361) 906-1277

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

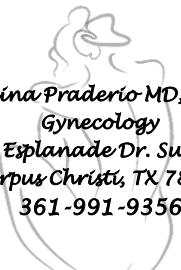
I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

Term: I understand that this Authorization will remain in effect as long as I am a patient of Dr. Praderio or until I submit a written request to Dr. Praderio requesting the cancellation of this authorization.

Signature: _____ Printed Name: _____ Date: _____

If minor, please complete: Parent or Guardian: _____ Relationship: _____

Address: _____
Street City State Zip


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TRANSFER OF CARE POLICY

NOTICE REGARDING SECOND OPINIONS, TRANSFER OF CARE AND VISITS WITH OTHER GYNECOLOGISTS

To help us serve you better, this policy will become effective January 1, 2016.

Dr. Praderio respects your right to see another Gynecologist. Whether it be for a second opinion or to transfer care, please note the following policy regarding patient transfers. Should you choose to visit another Gynecologist, **we will consider your request as a PERMANENT transfer of care.**

Initials

Patients who request a transfer of medical records to another gynecologist for whatever reason will be considered as a Transfer of Care. **Transfer of care means that Dr. Praderio will no longer be able to treat you as a patient once the request is made.**

Initials

Dr. Praderio cannot provide you with the best treatment possible if you are seeing another gynecologist. **IF** you are currently seeing another Gynecologist you **MUST** let Dr. Praderio know that you will transferring full and complete care to Dr. Praderio. **If it is discovered that you are seeing another gynecologist, Dr. Praderio will no longer be able to treat you as a patient.**

Initials

You understand that it is your right as a patient to seek a second opinion. You also understand that should you need to seek a second opinion **Dr. Praderio will no longer be able to treat you as a patient.**

The only exception to this policy will be:

- 1) Patients who are referred to another OBGYN for pregnancy
- 2) Referral by Dr. Praderio or to another specialist
- 3) Transfers because of a change to insurance coverage.
- 4) **NO OTHER EXCEPTIONS will be made.**

I have read and understand Dr. Praderio's Transfer of Care Policy and I agree to the terms of this policy.

Patient Signature

Date

Patient Name (Print Name)