ALL PATIENTS

GUSTAVO H. DAY. M.D., P.A.

PATIENT INFOMATION

Last Name: ______________________ **First Name:** ______________________

Date of Birth: ______________ **Sex:** M ____ F ____ **Marital Status:** M ____ S ____ D ____ W ____

Social Security #: ______________________ **Drivers License #:** ______________________

Address: ______________________ **City:** ____________ **State:** ____________ **Zip:** ____________

Home Phone: ______________________ **Work/Cell Phone:** ______________________

Employer Name: ______________________

Employer Address: ______________________ **City:** ____________ **State:** ____________ **Zip:** ____________

EMERGENCY CONTACT

Name: ______________________ **Phone #:** ____________ **Relation to Patient:** ____________

Power of Attorney (Print name): ______________________ **Phone #:** ____________ **Relation to Patient:** ____________

RESPONSIBLE PARTY

Guarantor (person responsible for bill): ______________________

Date of Birth: ______________ **Social Security #:** ______________________ **Sex:** M ____ F ____

Guarantor Phone #: ______________________ **Relation to Patient:** ______________________

Guarantor Address: ______________________ **City:** ____________ **State:** ____________ **Zip:** ____________

INSURANCE INFORMATION

Primary Insurance Name: ______________________ **Insurance Phone #:** ______________________

Insured's Name: ______________________ **ID #:** ____________ **Group #:** ____________

Insurance Address: ______________________ **City:** ____________ **State:** ____________ **Zip:** ____________

SECUNDARY INSURANCE INFORMATION

Secundary Insurance Name: ______________________ **Insurance Phone #:** ______________________

Insured's Name: ______________________ **ID #:** ____________ **Group #:** ____________

Insurance Address: ______________________ **City:** ____________ **State:** ____________ **Zip:** ____________

PHARMACY INFORMATION

Pharmacy Name and Phone Number: ______________________

Address: ______________________

FINANCIAL POLICY

We must have a copy of all insurance cards, driver's lisense or ID at the time of service. HMO, PPO, and Medicare patients must pay deducibles and co-pays. Co-pays and deducibles are expected at the time of service. Private pay patients must pay in full al the time of service. Patient must notify us if there is any change of insurance, address or phone number.

PATIENT SIGNATURE: ______________________ **DATE:** ____________ **E-MAIL:** ____________

Gustavo H. Day M.D., PA.
7777 Forest Lane, Suite B-416
Dallas, TX, 75230
Phone: (972) 566-6764

Assignment of Benefits

I hereby assign, transfer, and set over to Dr. Gustavo H. Day, all my rights, title, and interest to my medical reimbursement benefits under my insurance policy from my insurance company. I understand that I am financially responsable for non-covered services.

Insured or authorized signature	**Date**

Authorization to Release Information

I hereby authorize Dr. Gustavo H. Day to disclose all or part of my medical records to any insurance company or association, the Federal or State Government; as information may be necessary for the completion of all my medical claims.

I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/ or drug or alcohol abuse.

A copy shall be as valid as the original.

Insured or authorized signature	**Date**

GUSTAVO H. DAY M.D., P.A. NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is reuired by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain confidentiality of your health information. We realize theses laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the proper authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enorcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Comensation and similar programs.

Your Rights Regarding Your Health Information:

1. Communication. You can request that our practice communicate with you about your health in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.

2. You can request a restriction in or use or disclosure of your health Information for treatment, payment, or helthcare operations. You may request that we restrict the disclosure of your ealth information to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about tou, including medical records and billing records, but not including psychotherapy notes. You must submit your Request to Gustavo H. Day M.D., P.A. at (972) 566-6764.

4. You may ask us to amend your health information if you believe it is Incorrect or incomplete, and as long as the information is kept by our practice.

5. You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice please contact our front desk receptionist.

6. You have the right to file a complaint. You may file a complaint with our Practice or with the Secretary of Department of Health and uman Services. To file a complaint with our practice, please contact Gustavo H. Day M.D., P.A. at (972) 566-6764.

7. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions please contact our office at (972) 566-6764.

I hereby acknowledge that I have been presented with a copy of Gustavo H. Day M.D., P.A. Notice of Privacy Practices.

______________________________ ______________

Signature **Date**

____

Patient Name

If the patient is a minor:

____

Print Patient Name

______________________________ ______________

Parent or Guardian Signature **Date**

____

Print Parent or Guardian Name