Patient Demographics

Patient's Name: _____, _____ _____ Preferred Name: _____
Last (Apellido) Middle Initial (Inicial) First (Primero)

Address: _____ City: _____ State: ___ Zip Code: _____
Direccion Ciudad Estado

_____

Main Phone Number: _____ Secondary Phone Number: _____
Telefono

*This number will be used to send you an automated phone/text appointment reminder two days prior to your appointments.

DOB: _____ Social Security Number: _____ _____ _____ Marital Status: _____ Sex Female
Fecha de Nacimiento Seguro Social Estado Civil

Insurance

Primary Insurance: _____ Policy # _____ Group: _____
Seguro Primario Poliza Grupo

Policy Holder: _____ Policy Holder SSN: _____ Policy Holder DOB: _____
Nombre del derechohabiente Seguro del derechohabiente Fecha de nacimiento

Secondary Insurance: _____ Policy # _____ Group: _____
Seguro secundario Poliza Grupo

Policy Holder: _____ Policy Holder SSN: _____ Policy Holder DOB: _____
Nombre del derechohabiente Seguro del derechohabiente Fecha de nacimiento

Release of Information

I authorize the following person(s) to be present during my consultation, speak to the clinician and their staff over the phone regarding information pertaining to myself, or pick up a controlled substance prescription on my behalf. The doctor's office is free from any and all liabilities.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Other Providers

Primary Care Provider: _____ Phone Number: _____ Fax: _____

Specialists

Provider Name: _____ Specialty: _____

Phone Number: _____ Fax: _____

I authorize the release of any medical or other information necessary to process claims. I also request payment of government and/or any other third party payers benefits to the clinician who accepts assignment. I authorize payment directly to the clinician's office of the benefits otherwise payable to me but not to exceed the clinician's regular charges. I also understand that I am financially responsible to the clinician for charges not covered by this authorization. Signature below also acknowledges that I have read a copy of the clinician's office HIPAA notice of privacy practices.

_____ _____
Signature of Patient or Guardian Date

*If signed by a guardian or authorized representative, please provide legal documentation under state law (i.e. power of attorney, living will, guardianship documents, etc.).

Jorge A. Saravia, M.D.
Neurology

Santa Rosa North West Tower One 2829 Babcock Road, Ste. 436 San Antonio, Texas 78229 (210) 614-3659

We welcome you to our office and appreciate the opportunity to be of service to you. The following information is provided for your information so that we may better serve you. Please read each item and initial in the designated area.

(Initial each highligted line)

_____1. COPAYMENTS AND UNPAID BALANCES
All applicable fees, deductibles, coinsurance, co-pays, and account balances must be paid at the time of your appointment. We accept cash, checks, or money orders. We assess a $25.00 service fee for returned checks. Failure to pay any of the above may result in your account being turned over to a collection agency.

_____2. APPOINTMENTS CANCELLATIONS. UNKEPT APPOINTMENTS.
Scheduled appointments are reserved specifically for you. This office requires cancellation or rescheduling of an appointment 24 hours prior to the appointment date. If you do not keep your appointment, and fail to give proper notice for **two** of your scheduled appointments, your care will be terminated for non-compliance of treatment plan and you will be advised to see another physician. **There will be no exceptions to this policy.**

Additionally, if an appointment is missed no medication refills will be prescribed until the next scheduled appointment. Refills will be prescribed at the physician's discretion.

I am responsible for keeping my appointment card, which specifies my appointment date and time.

_____3. NEW INSURANCE COVERAGE
Notify this office at least 24 hours in advance of any changes on your current insurance status. **FAILURE TO DO SO MAY RESULT IN YOU BEING RESPONSIBLE FOR THE FULL OFFICE VISIT CHARGE.** I authorize the release of any medical documentation or other information necessary to process claims. I also request payment of government benefits and/or third party payer benefits to the pary who accepts assignment. I authorize payment directly to the doctor's office of the benefits otherwise payable to me but not to exceed the physician's regular charges. I also understand that I am financially responsible, to the physician for charges not covered by this authorization. Signature below also acknowledges that I have read a copy of the doctor's office HIPAA notice of privacy practices.

_____4. CONTACT INFORMATION
It is your responsibility to inform us of any changes to your address, phone number or other contact information. It is essential for us to have up-to-date information to reach you for appointment reminders or matters pertaining to your treatment.

_____5. IDENTIFICATION CARDS
All patients are required to have a valid State or Federal identification card with them at all appointments. If a patient does not have valid identification at the time of their office visit, the patient will be rescheduled and not seen until they present identification.

_____6. FORMS, LETTERS, ETC.
You will be charged $25.00 for any forms or letters needing to be filled out by the physician. Payment is due upon receipt of your form. Please allow five to seven business days to complete your requested paperwork. **Paperwork will not be completed from one day to the next.**

_____7. VERBAL ABUSE
Any verbal abuse toward Dr. Saravia, the clincians, or their staff will not be tolerated and will result in termination of service.

_____8. NON-COMPIANCE
We reserve the right to discontinue service for non-compliance of our policies and/or for non-compliance of the treatment plan outlined by Dr. Saravia.

_____9. IN CASE OF MEDICAL EMERGENCY
Go to the **nearest emergency room** or dial 911 or to the following hospital:
- Santa Rosa Northwest

_____ 10. **CONTROLLED SUBSTANCE MEDICATIONS**

Controlled substance medications are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. I agree to the following conditions:

I give consent to the clinicians and their staff to verify my filled prescription history either by contacting my other physicians, the pharmacy or through electronic verification.

I understand the medication, dosage and quantities prescribed to me are at the discretion of the clinician and are pertinent to my treatment plan. In the event I begin experiencing negative side effects, I will contact the office immediately or go to the nearest emergency room.

_____ 11. **CONSENT FOR TREATMENT**

I accept, understand and agree to participate in evaluation and/or treatment from Jorge Saravia, M.D. I understand that I may withdraw from treatment at any time.

I understand the main treatment goal is to improve my health and improve my ability to function at home and/or work. I must also comply with the treatment plan as prescribed by my physician. I understand a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

I have read the above office policy contract and fully understand the consequences of violating this agreement.

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Jorge A. Saravia MD Clinical History Review of Systems Current Medications	
Date	Date of Birth Age
Patient's Name	
What are your main symptoms or concerns?	

Have you had problems with	**Example**	**YES**	**NO**	**Describe and add as necessary**
General Symptoms	Weight Loss			
	Weight gain			
	Fatigue			
	Fever			
	Chills			
	Insomnia			
Skin	Rashes			
	Lumps			
	Eczema			
	Growths			
	Sores			
	Itching			
Lungs	Cough			
	Wheezing			
	Chest Pain			
	Snoring			
	Sleep Apnea			
Heart	Palpitations			
	Orthopnea (Difficulty to breath lying down) Syncope (fainting)			
	Edema (swelling)			
Stomach	Swallow difficulty			
	Stomach ache			
	Heartburn			
	Nausea			
	Vomiting			
	Constipation			
	Diarrhea			
	Rectal bleed			
				Turn Page over.....

Review of Systems

Have you had problems with	Example	YES	NO	Describe and or add others
Genito Urinary	Urgency			
	Frequency			
	Burning			
	Incontinence			
	Blood in Urine			
Blood	Easy bruising			
	Easy bleeding			
	Anemia			
Musculoskeletal	Muscle pain, Joint pain Joint redness			
Psychiatric	Depression			
	Anxiety			
	Stress			
	Memory loss			
Endocrine	Heat intolerance			
	Cold intolerance			
	Frequent urination			
	Excessive thirs			
	Apetite change			
Ear, nose and throat	Deafness			
	Ringing in ears			
	Ear ache			
	Nose bleeds			
	Sore throat			
Allergic/Immu-nologic	List youraAllergies			

List all medications currently taking			
Medication	**Dose**	**Prescribed by**	**Prescribed for**

email