ALDO F BEJARANO MD PA
3801 Vista Rd Suite 350-B
Pasadena, TX 77504

Patient Information

Date : _____

Name:_____
Last Name First Name Middle Initial

Address:_____
City State Zip

Phone: (___)_____ mobile phone: (___) _____ other: (___) _____

Date of birth_____ sex: feminine ( ) masculine ( ) language: _____

Ethnicity: Hispanic ( ) non-Hispanic ( ) race: _____

School Name: _____ Address:_____

Emergency Contact: _____ Telephone: (___) _____

Email _____

Responsible person

Name : _____ Relationship with the patient: _____

Address: (if different) _____
City State Zip

Date of birth_____ #ID: _____

Employer: _____ Employer Telephone: (___) _____

The insurance information

Name of insurance: _____ Secondary Insurance_____

Name of the insured: _____ Name of the insured: _____

Date of Birth: _____ Date of Birth: _____

Insurance Number: _____ Insurance Number: _____

Group Number: _____ Group Number: _____

Relationship with the patient: _____ Relationship with the patient: _____

Please list other relatives that are patients: _____

Allocation of benefits and payments policy of our Office

I authorize Aldo F. Bejarano, MD., P.A. to release my medical information necessary to process an insurance, insurance applications, and prescription drugs. I also authorize the payment of benefits to Aldo F. Bejarano, MD, PA.

Signature of patient or responsible _____ Date _____

To establish an excellent relationship with our patients and avoid misunderstandings and confusions; our employees are properly trained to inform about our payments policy. All payment for services provided at our Office will be in advance before our medical staff sees the patient. This includes insurance Co-Pays If you hold a balance that is sent to a collections service, there will be a charge of $10.00. Your signature below means that you agree and understand our policy.

Signature of patient or responsible _____ Date _____

Welcome Letter

Thank you for choosing Dr. Aldo F Bejarano as your medical provider

Dr. Bejarano and staff make all efforts to provide you with the best medical care and make sure your medical needs are met in a reasonable time. Maintaining an open communication with our patients is crucial to reach this goal which is why we like to share with you some of our office policies.

APPOINTMENTS: Even though we take walk-in patients, we prefer that you would call to reserve an appointment. A member of our staff will call the day before to remind you of your appointment. We have a cancellation policy that asks our patients to cancel their appointment at least 24 hours in advance to avoid a fee of $25.00.

PAYMENTS DUE AT TIME OF SERVICE: Co-pays will be collected up front and coinsurance at the end of the visit because the cost is based on the level of the visit. Self-pay patients will be asked to pay a fee at their arrival and at the end of the visit.

MEDICATION REFILLS: To avoid running out of medication, please CALL YOUR PHARMACY a week in advance. Do not wait until the medication is finished to call. The pharmacy will contact us. Once we receive the request, we will try to respond the same day unless an insurance authorization is required. Our Prescriptions Coordinator will keep you informed of any insurance issues.

TESTS: When Dr. Bejarano requests diagnostic tests such as an MRI, CT-SCAN, X-Rays, etc., a third party company will call you to coordinate the appointment with you and the facility where the test is being conducted. Allow them 2-3 days to contact you. If they do not hear from them during this time, call them at the number that we give to you at the end of the office visit. If a week passes by, please let us know. If the test is an emergency, we will set up the appointment and do what is necessary to obtain insurance authorization, if applicable

REFERRAL TO OTHER PHYSICIANS: We are subject to your health insurance regulations. Our referral coordinator will try to arrange an appointment with the specialist's office at the end of the visit. If authorization is needed, please allow us 3-4 days since we will need to fax or call your insurance for their approval. Our office will send the necessary paperwork to the other physicians' office. If after a week you have not heard from us, please call our office. We will find out what is causing the delay and inform you of any insurance issues.

LABORATORY ORDERS AND RESULTS: When Dr. Bejarano orders labs, we will send the order to the lab that is contracted with your insurance plan and to a location that is convenient for you. For lab results, we will contact you if a follow up appointment is needed and/or give you the doctor's new orders.

OTHER TEST RESULTS: Once we receive a report back from a facility or a specialist, we will contact you if further evaluation is needed or changes in medication are necessary. If we have not contacted you, it is because the results are not back or they came back normal. Dr. Bejarano will discuss them with you on your follow up appointment. Nevertheless, you are welcome to call for the results before that time.

MESSAGES FOR THE DOCTOR OR MEDICAL ASSISTANTS: Your messages will be checked throughout the day and returned in 24 hours. If the message is an emergency, we will contact you in the same day.

PERSONAL AND/OR INSURANCE INFORMATION CHANGES: Please keep us informed of any insurance changes by calling us. We have placed forms in the front window to facilitate this process. It is extremely important that we are aware of these changes since this will affect your medical care.

FINANCIAL RESPONSIBIUTY: Once again, please let us know if you change your insurance plan. There ate time filing deadlines that a provider needs to meet. If we do not meet them, the service will be denied, and we will have to bill you for these services.

PREVENTATIVE EXAMS: Our office recognizes the importance of preventative medicine. We will send you reminders throughout the year to let you know which exams or vaccines are due

PATIENT'S STATEMENTS: We will send statements in a monthly basis.

FORMS NOT RELATED TO YOUR MEDICAL CARE: There will be a $25.00 fee for filling out these forms. If an appointment is necessary and your health insurance does not cover it, a self-pay fee will be applied.

We hope this letter will contribute to a long lasting relationship and help us reach our goal in providing the best medical care possible.

Dr. Aldo F. Bejarano, M.D. Pediatrics

_____ _____ _____

Name Signature Date

ALDO F BEJARANO MD PA

PATIENT QUESTIONNARIE

Please list the family members or other persons, if any, whom we may inform about your son/daughter general medical condition and diagnosis (including treatment, and payments).

_____

_____

Please list the family members or other persons, if any, whom we may inform about your son/daughter general medical condition ONLY IN AN EMERGENCY.

_____ _____ _____

_____ _____ ___

Please indicate the address where you would like to receive your billing statements and/or correspondence from our office if other than your home address.

_____

_____

Please indicate if you want the correspondence from our office to be send in a sealed envelope marked "CONFIDENTIAL".

YES _____ NO _____

Please indicate the telephone number where you would like to receive calls about your child appointments, lab and x-ray results, or other health care information if other than your home phone number: _____

I am fully aware that a cell phone is not a secure line

Can confidential messages (i.e., appoint reminders) be left on your answering machine or voicemail? .

YES _____ NO _____

PATIENT NAME _____

_____

Parent/Guardian Signature Date

ALDO F. BEJARANO MD., P.A.

PEDIATRICS

3801 VISTA RD., SUITE 350 B

PASADENA, TX 77504

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.

Name _____ DOB _____

Signature _____

Date _____

FINANCIAL POLICY

Patient Name _____

It is the policy of this office that all patients, or their guarantors, are financially responsible for the services provided by Aldo F. Bejarano MD., P.A.

1. We expect co-pays to be paid at the time of service.
2. The office asks that all patients assign all insurance company payments directly to the practice to avoid any misunderstandings regarding payment for professional services. The patient will be responsible for any portion of his or her bill that is not covered by the insurance carrier. If the patient is a minor or unable to sign, the responsible party/guarantor who signed the consent to treat will be responsible for any portion not covered by the insurance carrier.
3. If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
4. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
5. Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, we will file an initial claim as a courtesy. Payment, however, is due in full at the time of service. It is your responsibility to verify this prior to your appointment.
6. We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
7. We may accept assignment after verification of your coverage. Please be aware that some or perhaps all of the services may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
8. All patients may be required to pay a pre-service deposit or estimated co-pays and deductibles prior to services.
9. You must provide your most current billing address, all available telephone numbers and any other important contact information and if any of this changes, it is your responsibility to contact us with the updated information.
10. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of any balance, it is your responsibility to contact our billing office within thirty (30 days after receipt of the initial statement).
11. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
12. In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $20.00 to your original balance.
13. We accept various methods of payment including credit card, money order and recurring payments. If you need to set up a payment plan, please talk to our billing department.

Again, thank you for your understanding and cooperation with this policy.

I do hereby understand and agree with the financial policy of Aldo F. Bejarano MD., P.A.

Relationship to patient: _____

Date : _____ Name person Signing _____

Signature of Responsible party/Guarantor (if necessary): _____

Dear Aldo F Bejarano, MD., P.A. Pediatrics Patient/Family,

Many patients have asked why we are collecting more demographic information this year. Our motivation is reflective of nationwide initiatives to improve patient care. As always, we are obligated by HIPAA privacy laws to use this private information for internal purposes only and not share with other entities unless it is integral to the delivery of your healthcare, or if we have explicitly received your permission to share.

It is voluntary on your part to provide answers to these questions. It is important for us to distinguish between patients whom **we** did not give the opportunity to answer the questions, versus those who chose not to provide a response.

Q. Why are we asking about race and ethnicity?

A. Many studies demonstrate disparities in the delivery of healthcare to different racial and ethnic groups. Programs across the country are looking to address these gaps in care. This can only be done if we have better knowledge of where these inequalities exist.

Q. Where did the categories of race and ethnicity come from?

A. The categories for race and ethnicity are based on standards published in the Federal Register and are mandated by Medicare/Medicaid "Meaningful Use" rules. This is very similar to the information you may have reported in a US Census survey. We understand that you may feel these categories do not apply to you, or may not be reflective of how you identify yourself, but we are required to follow these regulations without exception.

Q. Why are you asking about preferred language?

A. We know that sometimes medical information gets lost in translation between patients and medical staff. The first step in addressing any potential language problem is to identify what languages are preferred by our patients and parents.

Q. Why are you asking about contact preferences?

A. As technology advances, we know that patients have different preferences in how they would like to receive various kinds of information from our practice. The first step toward making improvements in patient communication is to collect preferences.

Ethnicity :	Hispanic	____	Race:	White	____
	Non- Hispanic	____		Black	____
	Decline to Answer	____		Asian	____
				Native American	____
Language:	English	___		Hawaiian Native	____
	Spanish	___		Decline to answer	____
	Other	___			

		Phone	Mail	email
Contact Method:	Medical Issues	_____	_____	_____
	Reminders	_____	_____	_____
	Recalls	_____	_____	_____
	Billing Statements	_____	_____	_____
	General Notices	_____	_____	_____
	Patient Portal	_____	_____	_____

Patient Name _____

Email _____

ALDO F BEJARANO MD., P.A.
3801 VISTA RD, SUITE 350B
PASADENA, TX 77504
(832)386-9200, FAX (832)386-9203

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**. Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions**. Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification**. Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Aldo F Bejarano MD., P.A. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Aldo F Bejarano MD., P.A. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

SIGNATURE OF GUARDIAN DATE