RACQUEL S. QUEMA, M.D., INC.

REGISTRATION FORM

(Please Print)

Today's date:	Attending Physician: Racquel Quema, M.D.

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Apt No. / P.O. box:

City:	State:	ZIP Code:

Home phone: ( )	Mobile phone: ( )	Email:	Preferred communication: ( ) Phone ( ) Email ( ) Text

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance	

Subscriber's name if different from Patient:	Birth date: / /	Group no:	Policy no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no:	Policy no:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone : ( )	Work phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Racquel Quema or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NOTICES

A. General Consent to Treat

I consent to medical care of a routine or emergency nature from the authorized professional staff of *Racquel S. Quema, M.D., Inc.* for myself or the person for whom I am the parent/guardian. _____ Initial

B. Payments & Insurance Notices

I authorize my insurance benefits to be paid directly to *Racquel S. Quema, M.D., Inc.* _____ Initial

I understand that I am financially responsible for any balances not paid by my insurance (example: co-pays, co-shares, deductibles, etc). _____ Initial

I authorize *Racquel S. Quema, M.D., Inc.* or insurance company to release any information required to process my claims. _____ Initial

C. HIPAA Notice

I acknowledge that I received Notice of Privacy Practices for *Racquel S. Quema, M.D., Inc.* and that I may obtain a paper copy of this Notice of Privacy Practices. _____ Initial

D. Notice About Open Payments Database

The Open Payments database is a federal tool used to search payments above $10 made by drug and device companies to physicians and teaching hospitals. Website: https://openpaymentsdata.cms.gov.

I acknowledge that I read the above notice about the Open Payments Database. _____ Initial

_____
Signature & Printed Name of Patient/Guarantor

Date: _____

NOTICIAS

A. Consentimiento General Para Tratar

Autorizo a la atencion medica de caracter rutinario o de emergencia del personal profesional autorizado de *Racquel S. Quema, M.D., Inc.* por mi mismo o por la persona por quien soy el padre / tutor. _____ Inicial

B. Aviso de Pagos y Seguro

Yo autorizo mis beneficios de seguro, si los hubiera, a ser pagados directamente a *Racquel S. Quema, M.D., Inc.* _____ Inicial

Entiendo que soy financieramente responsable de cualquier saldo no pagado por mi Seguro (ehemplo: copagos, deducibles, etc). _____ Inicial

Autorizo a *Racquel S. Quema, M.D., Inc.* o compania de seguros a divulgar cualquier informacion requerida para procesar mis reclamaciones. _____ Inicial

C. Declaracion HIPAA

Reconozco del Aviso de Practicas de Privacidad de *Racquel S. Quema, M.D., Inc.* y que puedo obtener una copia en papel de esta Aviso de Practicas de Privacidad. _____ Inicial

D. Aviso sobre Open Payments Database

The Open Payments database is a federal tool used to search payments above $10 made by drug and device companies to physicians and teaching hospitals. Website: https://openpaymentsdata.cms.gov.

Reconozco que leí el aviso anterior sobre la Open Payments Database. _____ Inicial

_____
Ferma y Imprimir Nombe del Paciente o Garante

Fecha: _____