Tandi Medical Center

10607 Liberty Field, Suite 103
San Antonio, TX 78254

Confidential Patient Registration Form

Please Print

___ New Patient
___ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

Date ___/___/____ Email Address: _____ Home Phone: _____ Work Phone: _____

Last Name_____First Name_____MI___ Cell Phone: _____

Street Address: _____ Mailing Address_____

City: _____ State _____ Zip_____

Gender: Male___ Female___ SSN: _____ - _____- _____ Birth-date ____/____/_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

☐ **Check here if information remains unchanged**

PREFERRED PHARMACY: _____ Pharmacy Location_____

Pharmacy Phone Number _____

Responsible Party/Spouse SSN: _____-_____-_____ Birth-date: ____/____/_____

☐ **Check here if information remains unchanged**

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

☐ **Check here if information remains unchanged**

In case of an emergency, who should be notified? _____

Relationship _____Phone: _____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Tandi Medical Center all benefits, if any, otherwise payable to me for his/her

Services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Tandi Medical Center

will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Tandi Medical Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care cooperation (TPO). With this consent, Tandi Medical Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others. I give permission for my medical information to be released to

To: _____ (Relationship) _____

_____ _____ _____
Signature of Patient, Parent or Guardian (circle one) Date DOB

Financial Policy

I have read and understand the financial policies of Tandi Medical Center. By my signature I agree to the terms outlined in the financial policies.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize Tandi Medical Center to provide medical care reasonable by today's standards, treatment and procedures will be will be performed by independent physicians and by the employees of this office. I hereby grant authorization and consent to such treatment and procedures.

_____ _____
Signature of Patient/Legal Guardian Date

Tandi Medical Center
10607 Liberty Field, Suite 103
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P 210-999-5586
F 210-999-5605
Appointment Policy
Please Print

24 HOUR APPOINTMENT CANCELLATION POLICY

If you cancel an appointment with less than 24 hour notice, you will be charged 35.00.

This policy is in place out of respect for the Family Practice and our clients. Cancellations with less than 24 hours are difficult to fill.

By giving last minute notice or no notice at all you prevent someone else from being able to schedule into that time slot.

By signing below you acknowledge that you have read and understand the Cancellation Policy for Tandi Medical Center.

Thank you for your understanding and cooperation.
Sandra L. Nieto, M.D.

_____ _____
Printed Name DOB

_____ _____
Signature Date