FORM MUST BE FILLED OUT COMPLETELY

Dr. Miguel Castellanos, M.D., P.A.
610 Strickland Dr., Suite 130
Orange, Texas 77630
(409) 886-7245

Date:_____

Last Name_____First Name:_____MI_____

Address_____City_____State_____Zip_____

Date of Birth_____SS#_____Male____Female____

Married____ Single____ Divorced____ Widowed____

Race_____ Ethnicity_____ Preferred Language_____

CONTACT INFORMATION

Home Phone:_____ Cell Phone:_____

Employment:_____Phone:_____

Responsible Party: Self____ Other:_____

FAMILY DOCTOR:_____

INSURANCE INFORMATION

Primary:_____ Secondary:_____

PERSONAL INFORMATION

Emergency Contact:_____ Phone:_____ Relation to Patient:_____

Nearest Relative:_____Phone:_____ Relation to Patient:_____
(Not living with you)

WE NEED TO MAKE A COPY OF YOUR INSURANCE CARDS AND DRIVERS LICENSE

ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS PREVIOUS ARRANGEMENTS ARE MADE PRIOR TO OFFICE VISIT

AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION

Print Patient Name: _____

I wish to be contacted in the following manner:

____ Home Phone: _____

____ Work Phone: _____

____ Cell Phone: _____

____ OK to mail to my home address OK to fax to this #_____

____ OK to leave detailed message on answering machine

You may release the following medical information to the person(s) listed below:

____ Test Results ____ Office Visits ____ Lab Work

____ Appointment Time ____ All Health Information

____ Other _____

You may release the information above to the following person(s), please check and print name:

____ Self Only ____Spouse _____

____ Daughter(s) _____

____ Son(s) _____

____ Grandchild_____

____ Other than above _____

_____

SIGNATURE OF PATIENT OR GUARDIAN

DATE:_____

This authorization will remain in effect and in force until I revoke it in writing, by sending a written notification to the following person or persons:

Robin Longest, N.P.
610 Strickland, Suite 100
Orange, TX 77630
(409) 886-7245

Miguel Castellanos, M.D., P.A.

FINANCIAL POLICY

Insurance benefits will be verified prior to patient coming in for appointment. To the best of our ability, we will figure the approximate amount due at the time of service after conversing with the insurance carrier. Please not that this is an **estimated** amount and does not ensure all benefits will be paid when the claim is processed.

All co-payments and co-insurance amounts and/or process are **due** at the time of service.

Prior to scheduling appointments and/or procedures, **all** patients due balances need to be **cleared**.

In the case where a large balance is due, we may be able to offer financial arrangements. The arrangement will be one-third at the time of service and the remaining balance will be divided in two payments within 60 days of the visit/procedure.

_____ _____

Patient Name Date of Birth

_____

Date

Dr. Miguel Castellanos, M.D., P.A.
610 Strickland Dr., Suite 130
Orange, Texas 77630
(409) 886-7245

CONSENT TO MEDICAL TREATMENT

PLEASE READ CAREFULLY BEFORE SIGNING

PATIENT NAME:_____ DATE OF BIRTH:_____

CONSENT TO MEDICAL TREATMENT/AUTHORIZATION TO RELEASE INFORMATION

I (for) undersigned patient do hereby voluntarily consent to such medical care involving routine diagnostic procedures and medical treatment ordered by my attending physician, his assistants or his designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this hospitalization/medical treatment. I further authorize the provider/physician to release to the insurers herein, specified, or to any agency concerned with the payment of my charges, any and all information (including copies of records) relating to this medical treatment.

RELEASE OF MEDICAL RECORDS TO TRANSFERRING FACILITY

I authorize the release of my medical records to the health care physician in order to provide continuity of medical treatment.

MEDICARE - PATIENT'S CERTIFICATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this related Medicare claim, I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE BENEFITS/DISTRIBUTION OF OVERPAYMENT/OBLIGATION OF GUARANTOR

Each of the undersigned hereby authorize all of (his) insurers, whether or not specified, to make payments of medical insurance benefits directly to the provider/physician rather than to said undersigned, but such payments shall not exceed the provider/physician regular charges not paid or covered by said insurers. Each of the undersigned insured's also hereby authorize any overpayment to the provider/physician regarding this hospitalization which would otherwise be payable to said undersigned to be applied and credited against any previous balance due the medical treatment for which said undersigned is the responsible party.

I also irrevocably assign to the provider/physician all rights, title and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any insurance guarantor, hereby guarantee full and prompt payment to the provider/physician of all charges made as a result of services rendered the above-named patient during this medical treatment. I agree to pay the provider/physician for said charges upon the failure of said patient, any responsible insurer or any other person or firm to pay same when due. The patient is responsible for any legal and court costs required in the collection of any unpaid accounts.

PHYSICIAN SERVICES/AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the release of any medical information necessary to process this claim. I hereby authorize payment directly to:

M.E. Castellanos, M.D.

Of the physicians service benefits, if any otherwise payable to me for their services described. I understand that I am financially responsible for the charges not covered by this authorization.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS.

_____ _____

PATIENT INSURED WITNESS

_____

GUARANTOR/INSURED

Miguel E. Castellanos, M.D., P.A.

610 Strickland, Suite 130
Orange, TX 77630
(409)-886-7245, Fax (409)-883-7450

I Authorize Dr:
Name: _____

Address: _____

City, St., Zip: _____

To Disclose To:
Name: _____

Address: _____

City, St., Zip: _____

I,_____, social security number _____, date of birth _____ am authorizing the release of my protected health information (PHI) as listed below.

Please check all that you wish to have released:

_____ Medical records, including history, exam notes and reports
_____ Medical records pertaining to alcohol and/or drug dependency reports
_____ Medical records pertaining to mental health treatment
_____ Medical records pertaining to HIV (aids) antibody test results and diagnosis/treatment
_____ Other: _____

This disclosure is being made for the following purpose(s):

___ Continuing Care
___ Attorney/Court Case
___ Review of Medical Records
___ Other: _____
___ Transfer of care
___ Insurance
___ Personal Reasons

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge of this service is $1.00 per page up to 25 pages, $0.50 per page up to 500 pages and $0.25 per page after that with a minimum charge of $7.50.

This authorization for disclosure of information is effective foe one year from date signed. The patient or legal guardian has the right to revoke this authorization. It must be in writing and will be effective on the date signed.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature Date

Relationship: ___ Legal Guardian ___ Executor of Estate ___ Spouse of Deceased
___Power of Attorney for Health Care ___Other:_____

MIGUEL E. CASTELLANOS M.D.P.A.
610 STRICKLAND SUITE 610
ORANGE, TEXAS 77630

MEDICATION SHEET

DATE:_____

NAME:_____ DOB:_____

ALLERGIES:_____

MEDICATION	DOSAGE	FREQUENCY	COMMENTS

MIGUEL E. CASTELLANOS, M.D. P.A.
610 STRICKLAND, SUITE 100
ORANGE, TEXAS 77630

STRESS TEST QUESTIONAIRE

WHAT IS YOUR HEIGHT _____ WEIGHT_____

PLEASE CIRCLE IF YOU ***CURRENTLY HAVE*** OR ***HAVE HAD***, IN THE LAST 6 WEEKS, ANY OF THE FOLLOWING PROBLEMS:

- CHEST PAIN/PRESSURE AT REST OR WITH ACTIVITY
- JAW/ARM PAIN AT REST OR WITH ACTIVITY
- SHORTNESS OF BREATH AT REST OR WITH ACTIVITY
- WAKE UP SHORT OF BREATH
- SWELLING OF HANDS OR FEET
- EXTRA/SKIPPED BEATS
- LIGHTHEADED/DIZZINESS/OR FAINTING
- UNSTEADY GAIT/STAGGER
- LEG PAIN WHILE WALKING
- WEAKNESS/FATIGUE

- DO YOU HAVE HIGH BLOOD PRESSURE OR TAKE MEDICATION FOR HIGH BLOOD PRESSURE? YES NO

- DO YOU HAVE ABNORMAL CHOLESTEROL/TRIGLYCERIDES OR TAKE MEDICATION FOR CHOLESTEROL OR TRYGLYCERIDES? YES NO

- HAVE YOU EVER HAD A HEART CATH (ARTERIOGRAM) (ANGIOGRAM)? YES NO

- HAVE YOU HAD BYPASS SURGERY? YES NO

- HAVE YOU EVER HAD SURGERY FOR AN ABDOMINAL AORTIC ANEURYSM? YES NO

- DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?
  DIABETES ASTHMA BRONCHITIS EMPHYSEMA THYROID DISEASE
  PREVIOUS LUNG SURGERY PREVIOUS HEART SURGERY

- DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING?
  HEART ATTACK OR DISEASE ANEURYSM STROKE MITRAL VALVE PROLAPSE

- DO YOU SMOKE / CHEW TOBACCO / OR DRINK ALCOHOL ON A REGULAR BASIS YES NO

  PLEASE LIST THE PRESCRIBED AND OVER THE COUNTER MEDICATIONS YOU ARE TAKING:

_____

_____

_____

_____

NAME:_____ DATE:_____

MIGUEL E. CASTELLANOS, M.D. P.A.
610 STRICKLAND, SUITE 100
ORANGE, TEXAS 77630

INFORMED CONSENT

I, _____ HEREBY AUTHORIZE MIGUEL CASTELLANOS, M.D.

AND SUCH TECHNICAL ASSISTANTS AS HE MAY SELECT, TO CARRY OUT THE DIAGNOSTIC PROCEDURE OF EXERCISE OR PHARMACOLOGIC ELECTROCARDIOGRAPHY WITH ECHOCARDIOGRAPHY. THIS WILL INVOLVE WALKING ON A MOTOR DRIVEN TREADMILL, OR RECEIVING AGENTS TO INCREASE THE HEART RATE TO SIMULATE EXERCISE. I UNDERSTAND THERE IS A SMALL BUT DEFINITE RISK IN UNDERGOING THIS TEST, BUT SINCE IT PROVIDES USEFUL INFORMATION TO MY PHYSICIAN, I MAKE THIS AUTHORIZATION.

PATIENT:_____

DATE:_____

PLEASE TURN TO THE REVERSE SIDE AND COMPLETE THE QUESTIONAIRE