Katy Psychiatry
Marco A. Reñazco, MD, PA
24215 Kingsland Boulevard
Katy, TX 77494
Office: 281-599-3313 Fax: 832-437-1132

PATIENT REGISTRATION FORM

DATE: _____

PATIENT INFORMATION

Last Name: _____
First Name: _____
Middle Name: _____
Sex: _____ Date of Birth: _____ Age: _____
Social Security Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Marital Status: _____

Referring Provider: _____

Emergency Contact Information
Name: _____
Phone: _____

Employer Information
Name: _____
Phone: _____

Guarantor Information (to whom statements are sent)
Relationship to Patient: Self / Spouse / Parent / Other
Name: _____
Address: _____
_____

INSURANCE INFORMATION

Policy Information
Insurance Plan: _____
Insurance Phone: _____

Patient's Relationship to policy holder: _____
Policy ID No: _____
Policy Group No: _____
Issue Date: _____ Exp. Date: _____
Copay: _____ Deductible: _____

Policy Holder
Last Name: _____
First Name: _____
Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Social Security No: _____
Sex: _____ Date of Birth: _____ Age: _____
Employer: _____

PHARMACY INFORMATION:

_____
Name of Pharmacy Pharmacy Phone Number Pharmacy Fax Number

_____
Pharmacy Street Address City State Zip Code

Other than you, your insurance company, and healthcare providers involved in your care, whom may we talk with about your healthcare information?

	NAME	TELEPHONE	RELATIONSHIP TO YOU
1.			
2.			
3.			

Is there any person/s you would like us NOT to speak to about your healthcare including appointments, etc.? Please list the specific person/s and the specific information you want restricted.

_____
_____
_____

_____
Signature of Patient / Legal Guardian / or Medical Power of Attorney Date Printed Name of Patient's Legal Guardian or Medical Power of Attorney *(if applicable)*

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CONSENT FOR MEDICAL TREATMENT

Form must be completed all individuals over the age of 18 years

I, _____ *(patient's name)* hereby voluntary consent to and authorize Katy Psychiatry and/or its authorized agents to provide me whatever medical treatment including mental health treatment and diagnostic procedures they may deem necessary while I am under their care. I acknowledge that no guarantees have been made as to the result of treatments or evaluations preformed at or by the providers of Katy Psychiatry.

Nature of expected treatment: Outpatient Psychiatric and Mental Health Care

Date Treatment is to begin: _____

This authorization may be revoked at any given time by providing Katy Psychiatry with a written and signed notice of said revocation.

This form has been fully explained to me and I certify that I understand its contents

_____

Signature of Patient Date

_____

Signature of Witness Date

****

Patient is unable to consent because: ☐ Minor *(younger than 18 years of age)* ☐ Other: _____

☐ Adult has no Medical Power of Attorney over self

I hereby consent on his / her behalf and in his / her stead this _____ day of _____ 20 _____ *(year)*.
(Exact date when patient turns 18 years old or Medical Power of Attorney declaration expires)

_____

Signature of Patient's Legal Guardian or Medical Power of Attorney Date

_____

Printed Name of Patient's Legal Guardian or Medical Power of Attorney Relationship to Patient

_____

Signature of Witness Date

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NOTICE

Pharmacogenomic Testing, Urine, and Blood Screens are tested / analyzed by agents or employees of Lab Corp (Laboratory Corporation of America) and their affiliates and assigns.

Lab Corp is **NOT** an employee of Katy Psychiatry or Marco A. Reñazco, MD. Lab Corp is an independent contractor of Katy Psychiatry and is a separate entity of Katy Psychiatry and Marco A. Reñazco, MD.

Katy Psychiatry and/or Marco A. Reñazco, MD does **NOT** accept responsibility for any actions or inaction on the part of Lab Corp or their affiliated and/or contracted labs including their employees, agents, or assigns.

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I have Read the above notice and agree to allow such pharmacogenomics testing, urine, and/or blood screens to take place. I also understand that I will not hold Katy Psychiatry or Marco A. Reñazco, MD or any employees of Katy Psychiatry responsible for any loss, physical, financial, or otherwise in connection with my consent to have such testing performed.

_____

Signature of Patient / Legal Guardian / or Medical Power of Attorney — Date

_____

Printed Name of Patient / Legal Guardian / or Medical Power of Attorney — Relationship to Patient

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Notice of Privacy Practice

I acknowledge that I have received a copy of the Notice of Privacy Practices as required under the Health Insurance Portability and Accountability Act (HIPAA). The notice I received describes how medical information about me may be used and disclosed and how I can get access to this information, including information on where to file a complaint regarding disclosure and use of protected health information under HIPAA.

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Assignment of Benefits and Release of Information and/or Certificate of NO Insurance

I certify that I, and/or my dependent(s), have insurance coverage with:

_____
Name of Insurance Company (ies)

and assign directly to Marco A. Reñazco, MD, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially liable for all charges whether or not paid by my insurance.

Further, if health insurance provider determines that services are not covered, I will be responsible for the full fees charged by the physician. I authorize the use if my signature on all insurance submissions.

Marco A. Reñazco, MD, PA may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services.

By signing below, I acknowledge that I have read and accepted the terms for both Notice of Privacy Practice & Assignment of Benefits and Release of Information and/or Certificate of NO Insurance

_____
Signature of Patient / Legal Guardian / or Medical Power of Attorney — Date

_____
Printed Name of Patient / Legal Guardian / or Medical Power of Attorney — Relationship to Patient

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OFFICE POLICY

Welcome to Katy Psychiatry, the office of Marco A. Reñazco, MD. This is a summary of our office policies developed to ensure your good health and the efficient operations of this office to better serve you.

OFFICE HOURS: The office is open Monday through Thursday 9:00 AM to 5:00 PM and Friday 9:00 AM to 4:00 PM. We are closed for lunch between 12:00 PM to 1:30 PM.

EMERGENCY: You may contact the office at the times listed above. After-hours and weekend calls are for emergencies only. You may be billed for services rendered after-hours, including phone calls.

APPOINTMENT CONFIRMATIONS: As a **COURTESY**, we will have our automated service call or text you regarding the date and time of your upcoming appointment at least 24 hours prior to your scheduled appointment. Even if you do **NOT** receive this appointment reminder, you are still responsible for any missed appointments or late cancellations and the associated fees.

CANCELLATIONS / MISSED APPOINTMENTS: If you are unable to come to your appointment, please call the office at least 24 hours in advance to cancel. If you do not give such notice, you will be charged $50.00 for each late cancellation and/or missed appointment.

EXTENDED SESSIONS: After the first initial evaluation, most follow-up appointments are scheduled 15 minutes apart. We will charge you and/or your insurance accordingly. However, there are times when your actual appointment with the healthcare provider may exceed the 15-minute scheduled time. When this happens, you and/or your insurance company will be charged for the additional time allowed. Additional charges will be collected upon check-out.

CONTINUED CARE: For your health and well-being, you are expected to keep your appointments for your continued care. If you have excessive missed or cancelled appointment, or you do not contact the office for six (6) months, you will be discharged from the practice. This includes timely cancellations of scheduled appointments. If you are discharged from the practice, you will be notified by mail with referral suggestions.

PAYMENTS / NSF CHECKS: Payment in full is expected **at the time service is rendered.** This includes co-payments, deductibles, and co-insurance. No third-party checks are accepted. All checks must be signed and presented by the same person and accompanied by the writer's valid driver's license or authorized photo ID. A $30.00 fee will be charged for returned checks. Any unpaid return checks and penalties will be turned over to the Harris County District Attorney's Office, Check Fraud Division, for processing. After receipt of a returned check, future payments will need to be made in cash, credit/debit card, or bank check.

PRESCRIPTIONS: Please keep track of your medication quantity and needed refills. If you need a refill, call your pharmacy and ask them to fax a refill request to us at 832-437-1132. Within two (2) business days, we will process the refill request and resend it back to the pharmacy. For a standard prescription, a one (1) month supply will be given. For a controlled substance, a prescription for a one (1) week supply will be given. **There will be a $10.00 fee for replacement of a controlled substance prescription.**

CONFIDENTIALITY: Your medical records are confidential and will not be released with your written consent. You will be asked to sign such contents for your insurance company, your agent or representative, and you referring physician, if applicable.

REPORTS: Any reports and forms for private / employer based disability insurance and related matters will be completed for a $50.00 charge per form or report. The fee must be paid prior to the release of the report/form. Copies of your medical records may be obtained for a $25.00 charge (for the 1st 20 pages) and $0.50 per page thereafter. Billing reports are separately charged. Some restrictions apply in accordance with the Texas Medical Board regulations and Federal laws.

ESTABLISHED PATEINTS: Annually, we will review your demographic and insurance information. Please keep us informed of any address, phone number, or insurance changes.

We reserve the right to immediately cancel your appointment for inappropriate conduct or language, non-compliance of medical treatment, or non-payment of balances.

I have read the office policies of Marco A. Reñazco, MD, PA (dba: Katy Psychiatry) and agree to abide by them as a patient of the practice or as a legal guardian seeking the necessary medical services of Katy Psychiatry for my dependent.

_____

Signature of Patient / Patient's Legal Guardian / or Medical Power of Attorney — Date

_____

Printed Name of Patient's Legal Guardian or Medical Power of Attorney *(if applicable)* — Relationship to Patient *(if applicable)*