Cardiology of San Antonio, P.A.
2833 Babcock #210, San Antonio, Texas 78229, Tel: (210) 949-1300; Fax:

Patient's Information	Referring Dr./PCP			PH: Fax:	
First Name MI Last Name	Female ___ Male ___	Date of Birth		SSN	Home Phone Number
Address	City	State	Zip Code	Occupation	Work Phone Number
Employer		Marital status Single ___ Married ___ Divorced ___ Widowed ___			

Primary Insurance

First Name MI Last Name	Date of Birth	Relationship to patient	Phone number
SSN / Start Date	Insurance Co	ID#	Group #

Secondary Insurance

First Name MI Last Name	Date of Birth	Relationship to patient	Phone number
SSN / Start Date	Insurance Co	ID#	Group #
Medicare Recpients Only: / MSP Code:			
12 Working Aged	41 Federal Black Lung		
13 End Stage Renal Disease (ESRD)	42 Veteran's Affairs		
14 Auto/Med/No-Fault Liability	43 Disability		
15 Worker's Compensation	44 Other Liability		

Tertiary Insurance

First Name MI Last Name	Date of Birth	Relationship to patient	Phone number
SSN / Start Date	Insurance Co	ID#	Group #

Emergency Contact	Name	Phone (H)	Phone (W)	Relationship

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Guillermo A. Reyes, M.D. of all insurance benefit otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, and for any service rendered to me or to my dependents.
I authorized the above mentioned doctor and/or any provider or supplier of service in this office to release the information required to secure the payment of benefits. I authorized the use of this signature on all insurance submissions.

Signature of Responsible Party_____ Date _____

I have received a copy of HIPAA Notice of Privacy Practices issued to me by Cardiology of San Antonio, P.A. on ____/____/____ . Signature _____

Disclosure Designation Notice of Private Information

I designate _____, my _____as my Qualified representative
Name of designee relationship to patient
as defined by the HIPAA rules; as such, I give permission to Cardiology of San Antonio, PA (COSAPA) to disclose any/all private health information that pertain to my care under COSAPA's supervision to my designate. I relieve and hold COSAPA blameless for any disclosure my designate deems appropriate He/She divulges to a Third Party.

Signature _____