SOLOMON PALEY, M.D., P.A.
BOARD CERTIFIED FAMILY PRACTICE

1314 E Sonterra Blvd, Ste 5203
San Antonio, TX 78258
Office (210) 946-6677
Fax (210) 946-6777

PATIENT INFORMATION

First Name_____ Last Name_____ MI____

Address_____APT_____

City_____ State_____ ZIP_____

Email address_____

Cell Phone (_____) _____ Home Phone (_____) _____

DOB_____/_____/_____ SSN_____-_____-_____ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Language _____

Race: ☐ Asian ☐ African American ☐ Caucasian ☐ More than 1 race ☐ Refuse

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse

Emergency Contact Name _____ phone (_____) _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Social Security # _____-_____-_____ D.O.B. _____/_____/_____

Member ID _____ Group ID _____

Secondary Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Social Security # _____-_____-_____ D.O.B. _____/_____/_____

Member ID _____ Group ID _____

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I, also, hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of Patient (or Parent if Minor) _____ Date _____

PATIENT CONSENT FOR MEDICAL TREATMENT

I have been informed of the treatment plan and the associated fees for the recommended treatment. I agree to be responsible for all the charges for medical services and materials not paid by my medical plan or insurance, unless the treating doctor or medical practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under the applicable law, I authorize release of any information relating to this claim.

I also understand that if I miss an appointment without providing a **24 HOUR NOTICE**, I will be billed an additional $25.00. **The $25 fee will be charged for the first missed visit. For every visit missed thereafter, a $50 fee will be charged.**

Signature of Patient (or Parent if Minor) _____ Date _____

NOTIFICATION OF RESULTS

I,_____, hereby request that I be notified of the results of my lab work, X-rays, EKG, Echocardiogram, NCS, ETC., only when results are abnormal.

Permission to leave results with _____

Leave message on voicemail (YES/NO) _____

_____
Patient Signature

HIPAA PRIVACY ACT

I have read a copy of this office's Notice of Privacy Practices.

_____
Printed Name of Patient

_____
Signature of Patient

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other: _____

_____ _____
Witness Date