Jaime Silva, M.D.
100 Uptown Ave. - Brownsville, TX 78520-7559
Phone: (956) 546-5500 • Fax: (956) 546-2035

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Referring Physician

Referring Physician: _____

Race and Ethnicity

Race _____ Preferred Language _____ Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Withhold

E-Mail and Text Messaging

E-Mail Address: _____ Would you like SMS text reminders? ☐ Yes ☐ No

If you would you like SMS text reminders; who is your cellular provider? _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Jaime Silva, M.D. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Please take the time to review the privacy notice (HIPPA) relating to your health informatiom. If you have any other questions that were not addressed in this document, please do not hesitate to contact us at: 956-546-5500

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

Cardiology
Jaime Silva, M.D., L.L.M., M.B.A
100 Uptown Ave. Telephone: (956) 546-5500
Brownsville, TX 78520 Fax: (956) 546-2035

Patient's Name:_____ Gender: Female ☐ Male ☐
SS No.:_____ DOB:_____ Age_____
Address:_____ City_____
State:_____ Zip Code:_____ Tel. No.:_____

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1. I authorize the use or disclosure of the health information described below.

2. The following individual or organization is authorized to make the disclosure:

_____ _____
Individual/Organization Address

3. The information may be disclosed to and used by the following individual or organization:

_____ _____
Individual/Organization Address

For the purpose of:_____

4. The information I authorize disclose is: From (Date):_____ To (Date):_____

Test Results (Please specify):_____ X-Ray & Imaging films
Pertinent part/abstract of medical records History & Physical
Discharge Summary Pathology slides
Any & All (medical records) Consultation
Designated Record Set (medical records, billing, other health care providers)
Other_____

5. I understand that my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services & treatment for alcohol & drug abuse.
6. I understand that I have a right to revoke this authorization at any time & that I must do so in writing to the Practice. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____if I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information before it is disclosed. I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact this Practice at: (956) 546-5500.
8. I understand there may be a fee for copying these records.
9. I authorize,_____to pick up the request copies of my health information & understand that he/she must prove their identity with a valid driver license or state identification card.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness