Dunamis Surgical Centers PLLC
1250 E. Cliff Ste 5A El Paso TX 79902 P: 915-532-1800 F: 888-694-2748

PATIENT INFORMATION

LAST NAME_____ FIRST_____
Apellido Primer Nombre
Social Security Number /Seguro Social_____-_____-_____

Date of Birth/Fecha de nacimiento: ____/____/____ _____ Gender: M / F

Address/Direccion: _____ APT.#_____

City & State/Ciudad Estado_____

Zip code/ Codigo postal_____

Home Phone/Telefono del domicilio (_____) _____

Cell Phone/Telefono cellular (_____) _____

Email Address/ Direccion de correo electronic©

Employer's Name & Address _____

Nombre Y Direccion del Empleador

Employer's Telephone Number (_____) _____

Telefono De Empleador

How did you hear about our office? _____

Como se entero de nuestra oficina

EMERGENCY CONTACT / CONTACTO DE EMERGENCIA

Name/Nombre _____

Relationship to Patient/ Relation con el paciente _____

Address/ Direccion_____

Home Phone/Telefono de Casa (_____) _____

Patient Medical History:
Historia Medica del Paciente

□Cancer	DHigh Cholesterol	DThyroid Disease
□Numbness	DDiabetes	^Hemorrhoids
□High Blood Pressure	DHemias	OGall Bladder

□Other Problems/Otros Problemas _____

Blood Thinners

□Asprin □Coumadin/Warfin DPIavix □Xarelto

Other: _____

Primary Insurance _____

Seguro Primario

I I Check if same as Patient/Seleccione si es mismo como paciente

Guarantor/ Guardian _____

Subscriber ID/ldentificacion de Suscriptor:_____

Group Number/ Numero de grupo_____

Claims Address_ _____

Relationship to Patient_____ Phone number _____
Relacion con el paciente Telefono
Date of Birth/Fecha de nacimiento _____/_____ / _____

Social Security Number/Seguro Social: _____ - _____-_____

Secondary Insurance _____
Seguro Secundario
| | Check if same as Patient/ Seleccione si es mismo como paciente

Guarantor/ Guardian _____

Subscriber ID/ Identification de Suscriptor: _____
Group Number/ Numero de grupo

Claims Address

Relationship to Patient Phone number
Relacion con el paciente Telefono
Date of Birth/Fecha de nacimiento / /

Social Security Number/Seguro Social:

ASSIGNMENT AND RELEASE

I certify that, I and/or my dependent(s), have insurance coverage with the above mentioned insurance company, and assign directly to DUNAMIS SURGICAL CENTERS, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Certifico que yo y / o mi (s), dependientes tienen cobertura de seguro de dependencia con la compahia de seguros antes mencionado, y asigno directamente a Dunamis Surgical Centers, PLLC todos los beneficios del seguro, en su caso, de otro modo asignados a mi por los servicios prestados. Entiendo que soy financieramente responsable de todos los cargos sean o no pagados por el seguro. Autorizo el uso de mi firma en todas las presentaciones de cargos al seguro.

DUNAMIS SURGICAL CENTERS, PLLC may use my health care information and may disclose information to the above insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Dunamis Surgical Centers, PLLC puede usar mi informacion de attention m^dica y divulgar informacion a la compafiia de seguros anterior (es) y sus agentes con el fin de obtener el pago de servicios y la determination de los beneficios del seguro a pagar por los servicios relacionados.

Signature Patient/ Responsible Party_____

Please Print Name _____

Relationship to Patient_____ Date _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act — 45 CFR Parts 160 and 164) L

1.1 hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI")

Records of care given by provider at *Dunamis Surgical Centers PLLC*

2. Authorization for release of PHI covering the period of health care all past, present and future periods.

3.1 hereby authorize the release of PHI as follows *(check one)x*

A. Dmy complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

B. Dmy complete health record *with the exception of the following information (check as appropriate):* □Mental health records DCommunicable diseases (including HIV and AIDS) DAlcohol/drug abuse treatment

□Other (please specify):_____ .

4. In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to die following individuals):

Name _ _____ Relationship _____
Name _____ Relationship _____
Name _ _____ Relationship _____

5. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6.1 understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7.1 understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8.1 understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date:

Signature of Patient

Printed Name

Dunamis Surgical Centers, PLLC

1250 E *Cliff Suite 5A El Paso, TX 79902 P: 915-532-1800 F: 888-694-2748*

Patient Consent to Treat

I hereby give my consent to Dunamis Surgical Centers, PPLC and authorize him/her to provide my medical treatment. I understand that Dunamis Surgical Center, PLLC will explain my condition (s), foreseeable risk, and methods of treatment for my condition before treatment is provided. I authorize Dunamis Surgical Center, PLLC to perform any additional treatment that is thought necessary it, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and fully understand this *Patient Consent to Treat* form and have the opportunity to discuss my condition and the above procedure (s) with the care provider.

All of my questions have been adequately answered.

Patient Name Printed:

Patient Signature:

Date:

Parent or Legal Guardian (if minor):

If Legal Guardian, relationship to patient:

Date