Francis M. Gumbel, M.D., P.A.

26 S. Coria St., Ste. B
Brownsville, TX 78520
Phone: (956) 546-4234 Fax: (956) 546-5806

First Name:	**MI:**	**Last Name:**
Previous Name Used:		
Date of Birth:	**Social Security Number:**	
Sex: Female Male Transgender	**Race:**	**Language:**
Marital Status: Married Single Widowed Divorced Legally Separated Other		
Mailing Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Cell:**	**Work:**
eMail:		
Place of Work:		
Do you posses a: Power of Attorney Living Will Advanced Directive		
Preferred Pharmacy:		
Emergency Contact's Name:	**Relation:**	
Emergency Contact's Home Phone:	**Cell Phone:**	
Primary Insurance:		
Secondary Insurance:		
Tertiary Insurance:		
Insured Complete Name:	**Relation:**	
Insured Date of Birth:	**Insured Social Security Number:**	
Insured Place of Work:	**Insured Work Phone:**	
Patient Signature:	**Date:**	

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Authorization for the Disclosure of Protected Health Information

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996, this authorization form gives **FRANCIS M. GUMBEL, M.D., P.A.** permission to acquire, use or release specified health information for treatment, payment, and healthcare operations.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Date of Service(s): _____ **Social Security #:** _____--____--_____

Information may be disclosed to: (Entity Name, Address, Phone & Fax)	**FRANCIS M. GUMBEL, M.D.**
Information may be disclosed by: (Entity Name, Address, Phone & Fax)	
Purpose for Use/Disclosure:	**Continuation Of Care**

Medical Information to be disclosed and/or photocopied include(s):

_____ My complete medical records.
_____ Progress Notes
_____ Radiology Reports
_____ Photographs, videos, digital or other images, media
_____ Other information (Specify): _____
_____ History and Physical
_____ Lab Reports
_____ Pathology Reports

I hereby authorize you to disclose copies of any medical record, which may include **Drug, Alcohol, Physical Abuse, and Mental Health, HIV/AIDS,** other medical conditions and social information.

I know that I have the right to withdraw this authorization, in writing, at any time by sending such written notice to **FRANCIS M. GUMBEL, M.D., P.A. Medical Records Department or Compliance Office.** I also know that information used or disclosed before this authorization may be subject to re-disclosure by the person who received the information and may no longer be protected by federal or state law.

Treatment, payment enrollment or eligibility for benefits may not be conditioned on obtaining this authorization

My permission is only in force and effect until the following date or event;

☐ _____ (List expiration date or event), or

☐ End of research study (use or release is for research).

Authorization will expire one year from the date of signature if no date is provided.

Date: _____ **Time:** _____

Signature of Patient or Authorized Legal Representative **(Relationship to Authorized Patient)**

Signature of Witness **Date**

DR. FRANCIS M. GUMBEL MD., PA

26 S CORIA ST STE B., BROWNSVILLE, TX 78520

PHONE 956-546-4234 FAX 956-546-5806

PREVIOUS MEDICAL PROVIDER (MEDICAL RECORDS)

NAME OF THE DOCTOR OR FACILITY	ADDRESS	PHONE NUMBER	FAX NUMBER	DATES OF SERVICE
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:
				FROM: TO:

FRANCIS M. GUMBEL, M.D.

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Appointment Compliance Policy

Our medical practice strives to provide our patients with the best medical care. We provide for our patients preventative services and follow up for chronic and acute illnesses.

In order to provide services for all of our patients we schedule new and follow up appointments and ask you notify us in advance if you are unable to keep your appointment.

Patients that fail to keep their appointments are considered no-shows and after three missed appointments will need to seek medical services elsewhere.

Thank you for choosing our office your medical services.

Poliza Por No Asistir A Su Cita

Nuestra práctica médica se esfuerza por ofrecer a nuestros pacientes la mejor atención médica. Proporcionamos a nuestros pacientes servicios preventivos y seguimiento de enfermedades crónicas y agudas.

Con el fin de proporcionar servicios para todos nuestros pacientes planificamos nuevas citas y seguimiento de las mismas y le pedimos que nos notifique anticipadamente si no puede asistir a su cita.

Los pacientes que no logran mantener sus citas son considerados incumplidos y después de tres citas perdidas tendrán que buscar los servicios médicos con otro medico.

Gracias por elegir nuestra oficina para sus servicios médicos.

Patient Name / Nombre Del Paciente	D.O.B./Fecha de Nacimiento
Patient Signature / Firma del Paciente	Date / Fecha

FRANCIS M. GUMBEL, M.D., P.A.

26 S. CORIA ST., STE. B, BROWNSVILLE, TX 78520

OFFICE PHONE: (956) 546-4234 FAX: (956) 546-5806

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Francis M. Gumbel, M.D.** access my pharmacy benefits data electronically through RxHub. This consent will enable **Francis M. Gumbel, M.D.** to:

- Determine the pharmacy benefits and drug co-pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download historic list of all medications prescribed for a patient by any other provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Name (Print) **Patient Signature**

Date of Birth **Date**

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
ADULT CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Last Name

First Name

Middle Name

For Clinic/Office Use

Date of Birth

Gender: Male Female

Address

Apartment #

Telephone

City

State

Zip Code

County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (# C-7). The ImmTrac Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac. Once in ImmTrac, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____
Printed Name

_____ _____
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EF11-13366
Revised 05/18/12

TEXAS Department of State Health Services

***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.*

FRANCIS M. GUMBEL, M.D., P.A.

Acknowledgement of Receipt of Notice of Privacy Practice
El Reconocimiento de Recibo de Nota de la Intimidad Practica

I understand that **Francis M. Gumbel, M.D.** will use and disclose any medical information regarding my treatment, payment and health care operations.

The practice of **Francis M. Gumbel, M.D.** reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **The Practice of Francis M. Gumbel, M.D.** This signed copy will be kept in the patient's billing chart.

Yo entiendo que Francis M. Gumbel, M.D. usara y revelara informacion medica con respecto a mi tratamiento, el pago y las operaciones del cuidado de la salud.

La Practica de Francis M. Gumbel, M.D. reserva el derecho de modificar la intimidad practica resumida en la nota.

Yo he recibido copia de la Nota de Practicas de Intimidad para La Practica de Francis M. Gumbel, M.D. Una copia firmada por el paciente se mantendra en el expediente de cobranza.

Name of Patient (Print) / Nombre del Paciente (letra molde)

⊗

Patient Signature/Firma del Paciente | **Patient Representative/Representante del Paciente**

⊗

Date/Fecha | **Relationship to Patient/Relacion al Paciente**

Signature of Patient Representative is required if the patient is a minor or an adult who is unable to sign this form.

La firma del Representante del Paciente se requiere si el paciente es un menor o un adulto que no tiene la capazidad de firmar esta forma.

I understan: / ***Yo entiendo:***

- ⊗ I am responsible for my bill / *Yo soy responsable de mi cuenta*
- ⊗ My doctor will act as my agent in helping me obtain payment form my insurance company / *Mi doctor actuara como mi agente para ayudarme a obtener pago de mi compania de seguro*
- ⊗ Payments will be directly to my doctor / *Los pagos seran directamente a mi doctor*
- ⊗ A copy of this form is permitted to be used in place of the original / *Una copia de esta forma sera permitida ser usada en lugar de la original*

(For Office Use Only)

Attempt to Obtain Acknowledgement

An attempt was made to obtain Acknowledgement of Receipt of the Notice of Privacy Practices on ____/____/____

____ The patient was undergoing emergency treatment

____ Other: _____

____ The patient declined to sign the acknowledgement

Name of Staff Member: _____

Date: ____/____/____

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Authorization of Use and Disclosure of Protected Health Information
Autorización de uso y divulgación de información de salud protegida

Information to be Used or Disclosed / *Información a ser usada o revelada*
The information covered by this authorization includes: / *La información cubeirata por esta autorización incluye:*

_____

_____

_____

Purpose of Disclosure / *Propósito de la divulgación*
Information listed above will be disclosed for the following purpose: / *Información mencionada anteriormente será compartida con i siguiente propósito*

_____

_____

Persons Authorized to Use of Disclose Information / *Personas autorizadas a usar o divulgar información*
Information listed above will be used or disclosed by: / *La información mencionada anteriormente será usada o divulgada por*

_____
Name of person or organization / *Nombre de la persona o la organizacion*

_____
Name of person or organization / *Nombre de la persona o la organizacion*

_____
Name of person or organization / *Nombre de la persona o la organizacion*

Persons to Whom Information May Be Disclosed / *Personas a las que se puede revelar información*
Information described above may be disclosed to: / *Información descrita anteriormente puede ser revelada a*

_____
Name of person or organization / *Nombre de la persona o la organizacion*

_____
Name of person or organization / *Nombre de la persona o la organizacion*

_____
Name of person or organization / *Nombre de la persona o la organización*

Expiration Date of Authorization / *Fecha de vencimiento de la autorización*

This authorization effective through ____/____/_____ unless revoked or terminated earlier by the patient of the patient's personal representative.

Esta autorizacion es efectiva asata ____/____/_____ menos que sea revocado o rescindido por parte del paciente o del representante personal del paciente.