

Antonio E. Mancera, MD  
10410 Medical Loop Unit 6B Laredo, TX 78045 Ph: 956-728-8121 Fax: 877-389-4038

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### New Patient Packet

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender: \_\_\_\_\_ Marital Status: Single / Married / Divorced / Widow

Ethnicity/Race (can decline) \_\_\_\_\_ Language \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care (General) Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Address: \_\_\_\_\_

Referring Doctor Name: \_\_\_\_\_

### Preferred Pharmacy

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

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## MEDICAL RECORDS REQUEST FORM

I hereby authorize the Medical Group / Physician named below to release my medical records/protected health information to Laredo Arthritis & Rheumatology Center, PLLC:

Medical Group(s) / Physician(s): \_\_\_\_\_

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Please Release the following:

Entire Record  Clinical Notes  Labs  X-Rays  Diagnostic Tests

Other: Biopsies, MRI's, EMGs, CT Scans, PFT'S, echocardiogram reports

I give permission for the release of any information in my records including information relevant to substance abuse, psychiatric/mental health services, and/or HIV information. I grant this authorization for a period of one hundred eighty (180) days. I may revoke this authorization at any time in writing although I cannot undo its prior use.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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## NOTICE OF PRIVACY PRACTICES

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. LAREDO ARTHRITIS & RHEUMATOLOGY CENTER, PLLC (LARC)*

This privacy notice applies to all of the records of your care generated by **LARC**. Your other medical providers or may have different policies or notices regarding their use and disclosure of your medical information created in their office or clinic. This privacy notice will tell you how we use and disclose medical information about you. It also describes your rights and certain obligations regarding the use and disclosure of medical information.

We may use medical information about you to:

- provide medical treatment or services including the coordination of your care with other providers and facilities;
- bill for and receive payment for treatment you have received including sharing such information with your health insurer when necessary;
- review our treatment and services and to evaluate the performance of our staff in caring for you and to comply with health oversight activities;
- decide what additional services the clinic should offer, what services are not needed, and whether certain new treatments are effective;
- assist with teaching and learning for doctors, and other health care professionals, and health care students,
- remind you of an appointment;
- assist persons who are involved in your medical care;
- comply with federal, state, and local law, military authority or to prevent a serious threat to your health and safety or the health and safety of the public or another person;
- protect your health and safety or the health and safety of others; and/or
- make disclosures without notice to you where required under applicable law and situations such as public health issues/concerns, communicable disease issues, health oversight, abuse or neglect concerns, legal proceedings, national/Homeland security, military security, workers compensation, or for the safety and security of the correctional institution for inmates.

You have a right to:

- inspect and copy medical information that may be used to make medical decisions about your care except for psychotherapy notes, information compiled in anticipation of or for use in a civil, criminal, or administrative proceeding, and any other protected health information which you are not permitted to inspect or copy by law;
- request an amendment of your record;
- request an accounting of disclosures of medical information;
- request a restriction or limitation on the medical information we disclose about you for treatment, payment, or health care operations;
- request that we communicate with you about medical matters in a certain way or at a certain location;
- file a complaint with **LARC** or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. **You will not be penalized for filing a complaint.**

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## OFFICE POLICIES of Laredo Arthritis & Rheumatology Center, PLLC

Welcome! I am honored to be one of your new doctors. I consider my patients to be part of our family. I know you are probably in pain or have many questions. I will try my best to help you feel better, listen to all your questions and concerns, give you the shortest wait time possible, and give you the best medical experience. I kindly ask that you read and agree with our policies and rules. Thank you.

-Antonio E. Mancera, M.D.

### PLEASE INITIAL BY EACH NUMBER:

#### \_\_\_\_\_ 1. PAYMENTS:

All fees or co-pays are due BEFORE you see the doctor.

Co-insurance and deductible fees are due at check-out.

If you have a question about these charges, we can call your insurance company for you at the time of the visit.

There will be a **\$15.00** charge for all returned checks.

\_\_\_\_\_ 2. Forms or letters such as FMLA, disability etc. are **\$15.00**. We may not be able to fill some types of disability form requests.

\_\_\_\_\_ 3. Request for Complete Medical Records are **\$15.00**

\_\_\_\_\_ 4. ~~Kindly call to cancel or reschedule your appointment within 24hrs or you will be charged a **\$10.00** fee.~~ Replaced by number 13.

\_\_\_\_\_ 5. Please have a primary care (General) doctor or we can refer you to one. Dr. Mancera only focuses on arthritis and Rheumatologic conditions.

\_\_\_\_\_ 6. If you have an urgent issue after our business hours and need to be seen by a doctor, please go to a clinic or emergency room.

\_\_\_\_\_ 7. If you call with questions for the Doctor, he will try his best to call you back that evening after clinic. Please do not use the fax machine to ask us questions.

\_\_\_\_\_ 8. Please give us **2 business days** to refill a prescription.

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\_\_\_\_\_9. Please bring your medications to your visit unless they have to be refrigerated.

\_\_\_\_\_10. **NARCOTICS:** Dr. Mancera does not refill narcotic prescriptions from other doctors. We may refer you to pain management if you require strong narcotics. Dr. Mancera does NOT prescribe narcotics for fibromyalgia.

\_\_\_\_\_11. **OFFICE COURTESY:**

- Only if you can**, please leave small children in the waiting room with a family member or friend.
- Please do not leave children unattended at any time.
- Please take your children outside if they are too loud.
- ~~-We may reschedule you if you are more than 15 minutes late as a courtesy to other patients.~~
- Do not take the magazines home.
- Do not put your feet on the couches.
- Do not take pictures or videos of office procedures.
- We **WILL** reschedule if you are more than 30 minutes late as a courtesy to other patients.

\_\_\_\_\_12. Unfortunately, it is sometimes necessary to end the patient/doctor relationship. We will provide written notice of the termination and comply with state regulations.

Possible causes for termination include being rude or threatening, multiple no-shows, or not getting necessary lab tests to monitor your medications.

\_\_\_\_\_13. **NO SHOW FEE (New Patients Only):**

If for any reason you are unable to cancel 24 hours prior to your appointment, you will then be charged a \$25.00 No-show fee.

## **Polizas de la Oficina Laredo Arthritis & Rheumatology Center, PLLC**

Bienvenido(a)! Es un honor ser uno de sus doctores nuevos. Yo considero a mis pacientes como parte de mi familia. Yo se que probablemente sienta dolor o que tenga muchas preguntas. Yo hare mi mejor intento para ayudarle a sentirse mejor, escuchar sus preguntas o preocupaciones, atenderlo lo mas pronto posible, y darle la mejor atencion medica. Le pido atentamente que porfavor lea y este de acuerdo con mis polizas y reglas. Muchas Gracias.

- Antonio E. Mancera, M.D.

### **FAVOR DE ESCRIBIR SUS INICIALES A LADO DE CADA NUMERO:**

#### **\_\_\_\_1. PAGOS:**

Todos los pagos se daran ANTES de ver al doctor.

Pagos de Co-insurance y deducibles se daran al SALIR de su visita.

Si usted tiene alguna pregunta de los cargos, nosotros podemos llamar a su compania de aseguranza durante el tiempo de su visita.

Se le dara un cargo de \$15 por cheques que no sean aceptados.

\_\_\_\_2. Se cobrara \$15 para formas o cartas para "FMLA" o discapacidad. Habran algunas formas de discapacidad que no podremos llenar.

\_\_\_\_3. Se cobrara \$15 para copias de archibos medicos.

~~\_\_\_\_4. Favor de hablar para cancelar su cita 24 horas antes o se le cobrara \$10.00~~

\_\_\_\_5. Favor de tener un doctor primario o si no le podemos recomendar a uno. El Dr. Mancera es especialista y solo se hace cargo de enfermedades de reumatologia y artritis.

\_\_\_\_6. Si tiene alguna emergencia despues de nuestras horas de consultas y se tiene que ver por un doctor, favor de ir a una clinica o al cuarto de emergencia del hospital.

\_\_\_\_7. Si llama con preguntas para el doctor, el hará su mayor intento de regresarle la llamada después de que termine con todas sus consultas del día. Favor de no usar el fax para hacer preguntas.

\_\_\_\_8. Favor de darnos 2 días de oficina para llenarles sus recetas de medicinas.

\_\_\_\_9. Favor de traer sus medicinas a sus citas al menos que tengan que estar refrigeradas.

\_\_\_\_10. **NARCOTICOS:** El Dr. Mancera no llena recetas narcóticas de otros doctores. Le podemos hacer una referencia a un doctor de dolor si usted requiere narcóticos fuertes. El Dr. Mancera NO receta narcóticos para fibromialgia.

\_\_\_\_11. **CORTESIA DE LA OFICINA:**

-Únicamente si puede, favor de dejar niños chiquitos en la sala de espera con algún miembro familiar o amigo.

-Favor de no dejar a niños sin atender en cualquier momento.

-Favor de salirse afuera si sus niños están haciendo mucho ruido.

~~-Si llega más de 15 minutos tarde, le podemos cambiar su cita por cortesía a otros pacientes.~~

-Favor de no llevarse las revistas.

-Favor de no subir los pies a los sillones.

-Favor de no tomar fotos o videos de procedimientos en la oficina.

-Si llega más de 30 minutos tarde, se le va a cambiar su cita por cortesía a otros pacientes.

\_\_\_\_12. Desafortunadamente, a veces es necesario terminar la relación entre paciente y doctor. Si esto ocurre, le daremos aviso por escrito y cumpliremos con reglamentos estatales.

Algunas causas posibles para terminar la relación incluyen: ser groceros o amenazar, no cumplir con sus citas varias veces, o no hacerse los exámenes de laboratorio necesarios para controlar sus medicamentos.

\_\_\_\_13. Cuota por no aparecer (Pacientes Nuevos Solamente):

Si por cualquier razón no cancela su cita antes de 24 horas, se le cobraría \$25.00 por no aparecer a su cita.

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I have reviewed and agree with the Notice of Privacy Practices and Office Policies Forms. I also authorize my insurance benefits be paid directly to the physician.

If I have Medicare, I understand some services/treatments may not be covered by Medicare. I will be notified in writing before these services/treatments are done if my doctor believes that Medicare will not pay for them.

I understand that I am financially responsible for any balance. If my insurance does not pay for my balance I will pay it. I also authorize Laredo Arthritis & Rheumatology Center, PLLC or my insurance company to release any information required to process my claims.

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Patient Signature

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Date