Arturo A. Bravo, MD
Gastroenterology

Arturo A. Bravo, MD PA
16700 House & Hahl Rd
Building 3, Cypress, TX 77433
www.bravogastro.com

Patient Registration Form

Welcome to Our Practice

Date _____

Patient's Name: _____ _____ _____ **SS#:** _____
First Name MI Last Name

Date of Birth: _____ ◯ Male ◯ Female ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Separated

Street Address: _____

City/State/Zip Code: _____

Primary Contact Phone Number: _____

Secondary Contact Phone Number: _____ Work Phone: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Email (if available) _____

In case of emergency, Contact Person: _____

Phone Number w/Area Code: _____ **Relationship to Patient:** _____

With whom may we share medical records? _____

Pharmacy Information (Very Important)

Name: _____

Phone Number: _____

Address: _____

Who is your primary care physician? _____ **Tel** _____

Who is your referring care physician? _____ **Tel** _____

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Arturo A. Bravo, MD PA
11307 FM 1960 West, Suite 370
Houston, TX 77065
www.bravogastro.com

Patient Notice

Patients please read the following:

1. There will be a $25.00 charge for a broken appointment unless 24hr notice is given
2. Payment is expected at the time services are rendered unless prior financial arrangements have been made.
3. Please notify the front desk of any change **in *address, phone, or insurance coverage*** prior to your appointment. If you supply this information on the day of your appointment, you will have to wait until we can verify all information. In some instances, you may be asked to reschedule.
4. It is your responsibility as a patient to make sure we have a valid referral for your visit or you will be asked to pay for the visit in full.
5. There is a 35.00 fee for copies of medical records, FMLA forms, disability forms, and attending physician statements needing to be completed. The fee is waived for copies for records sent directly to another attending physician.
6. There will be a $25.00 handling fee for returned checks.
7. I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check or credit card.
8. I have read and/or been supplied with a copy (copy at patient request) or the HIPPA policies of Dr. Arturo Bravo. _____ **(initials)**

I have read and understand this Patient Notice.

_____ _____

Patient Signature **Date**

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Patient Registration Form, Continued

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for the various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with insurer).

Signature: _____ **Date:** _____