



NAVIGATION
MEDICAL CENTER

Jaime E. Duarte MD FAFP
Sonia P. Moncayo MD

3003 Navigation Blvd., Houston, TX 77003. Fax: 713-223-1571 Phone: 713-223-4466
www.navigationmedical.com

REGISTRATION FORM / HOJA DE REGISTRO

Date / Fecha:

PCP / Médico primario:

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

Patient / Paciente:

Last name / Apellido

First name / Primer nombre

Marital status / Estado civil: (check one / seleccione uno)

Single / Soltero Married / Casado

Preferred language / Idioma preferido:

English / Inglés

Spanish / Español

Divorced/Divorciado Widow(er)/Viudo(a)

Gender / Género:

M

F

Birth date / Fecha de nacimiento:

m / d / y/a

Age / Edad:

Address / Dirección:

City / Ciudad

State / Estado

ZIP Code

Sexual Orientation / Orientación Sexual

Straight or Heterosexual / Heterosexual

Lesbian, gay or Homosexual / Lesbiana u Homosexual

Bisexual / Bisexual

Choose not to disclose / Prefiero no decir

Other / Otro : _____

Gender Identity / Identidad de Género

Male / Masculino

Female / Femenino

Transgender Male / Transgenero Masculino

Transgender Female / Transgenero Femenino

Other / Otro : _____

Race / Raza:

White / Blanco

African American/ Afro Americano

Asian / Asiatico

Otro: _____

Ethnic / Etnia:

Hispanic / Hispano

Not Hispanic / No Hispano

Social Security No. / No. del Seguro Social:

EMPLOYMENT INFORMATION / INFORMACIÓN LABORAL

Mobile phone No. / No. de móvil:

Occupation / Ocupación:

Home phone No. / No. Teléfono fijo:

Employer / Empleador:

E-mail address / Correo electrónico:

Contact phone No. / No. De contacto:

INSURANCE INFORMATION / INFORMACIÓN DEL SEGURO

Is this patient covered by insurance? / ¿Esta cubierto este paciente por un seguro médico?

No / No (Continue in 1. / Continuar en 1.)

Yes / Si (Continue in 2. / Continuar en 2.)

1. Person responsible for bill / Persona responsable de la cuenta:

Birth date / Fecha de nacimiento:

Contact phone No. / No. De contacto:

Last name / Apellido

First name / Primer nombre

m / m d / d y / a

2. Name of the **primary** insurance company / Nombre de la compañía de seguro médico **primario**:

Subscriber's name / Nombre del suscriptor:

Birth date / Fecha de nacimiento:

Policy No. / No. Poliza

Group No. / No. Grupo

Last name / Apellido

First name / Primer nombre

m / m d / d y / a

Patient's relationship to subscriber / Relación del paciente con el suscriptor:

Self / Mismo

Spouse / Esposo (a)

Child / Hijo (a)

Other / Otro: _____

(If applicable / Si aplica) Name of the **secondary** insurance company / compañía de seguro médico **secundaria**:

Nombre de la

Subscriber's name / Nombre del suscriptor:

Birth date / Fecha de nacimiento:

Policy No. / No. Poliza

Group No. / No. Grupo

Last name / Apellido

First name / Primer nombre

m / m d / d y / a

Patient's relationship to subscriber / Relación del paciente con el suscriptor:

Self / Mismo

Spouse / Esposo (a)

Child / Hijo (a)

Other / Otro: _____

IN CASE OF EMERGENCY / EN CASO DE EMERGENCIA

Name of local friend or relative / Nombre de amigo o familiar:

Relationship to patient / Relación con el paciente:

Home phone No. / No. Teléfono fijo:

Mobile phone No. / No. de móvil:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Navigation Medical Center or the Insurance Company to release any information required to process my claims.

La información anterior es verdadera. Autorizo a mi seguro pagar directamente al médico según beneficios. Entiendo que soy financieramente responsable de cualquier balance. También autorizo a Navigation Medical Center o la compañía de seguros para suministrar toda la información necesaria para procesar los reclamos correspondientes.

Patient / Guardian signature
Firma del paciente o responsable

Internal Use:

Received/Reviewed by: _____



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NEW PATIENT CONSENT & ACKNOWLEDGMENT FORM CONTROLLED MEDICATIONS POLICY

Patient Name: _____ **Date of Birth:** _____

At **NAVIGATION MEDICAL CENTER**, we are committed to providing high-quality, evidence-based care focused on your health and well-being. As part of our clinic policy and care philosophy, we **do NOT prescribe or manage controlled medications** including, but not limited to:

Opioids (e.g., Hydrocodone, Oxycodone, Morphine, etc.)

Benzodiazepines (e.g., Xanax, Ativan, Valium, etc.)

Stimulants (e.g., Adderall, Ritalin, etc.)

Sleep medications (e.g., Ambien, Lunesta, etc.)

We understand that some patients may have been prescribed these medications in the past. However, our practice emphasizes safer, alternative approaches to pain management, anxiety, ADHD, and sleep concerns that align with current medical guidelines and public health standards.

If you require continued treatment with controlled substances, we encourage you to discuss care options with your previous provider or seek referral to a specialist in pain management, psychiatry, or behavioral health.

Patient Acknowledgment:

By signing this document, I acknowledge that:

NAVIGATION MEDICAL CENTER does not prescribe or manage controlled medications. I understand that I will not receive prescriptions for opioids, benzodiazepines, stimulants, or similar controlled substances from this clinic.

I agree to discuss alternative, evidence-based treatment options with my provider as appropriate.

I understand that failure to comply with this policy may result in dismissal from the practice.

I agree that NAVIGATION MEDICAL CENTER reviews my pharmacy information as well as access into PBM and PMP to improve my health outcomes and medication management.

Patient Signature: _____ **Date:** _____



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LATE ARRIVAL, CANCELATION AND NO-SHOW POLICY

We, at **Navigation Medical Center** strive to provide high quality health care to all our patients in a timely manner. Failure to keep scheduled appointments is costly not only to the clinic but also to you as a patient. Late arrivals beyond 15 minutes of your expected appointment can cause significant inconvenience not only to the healthcare providers, but also to other patients.

For new patients, we routinely recommend that you plan to arrive at least 30 minutes in advance of your first visit if you haven't had a chance to complete the paperwork in paper or electronically.

Late arrivals are defined as arrivals 15 minutes past the scheduled appointment time and will need to be re-scheduled. However, depending on the workflow of the clinic, we may or may not be able to accommodate you. This can only be determined by the clinic staff after your arrival. In certain cases, you are supposed to have a PCP assigned and you did not do it prior to your appointment, time spent on doing it past the 15 minutes courtesy, you may need to re-schedule your appointment. (Same applies for any other matters that delay your registration process). **Arriving late for second time in same calendar year will carry a charge of \$50 fee.**

Patients who are unable to keep their appointments are requested to give 48-hour notice prior to their appointment. We realize it is not always possible to provide this notice, and we will consider this on a case-by-case basis. Providing such notice allows the clinic time to offer other patients the opportunity to see our providers, thus using the clinic time more efficiently.

If an established patient **fails to provide notice 48 hours prior to the appointment, it will be necessary to charge a \$50.00 fee** that will be billed to his/her account. If a patient fails to keep 3 appointments per calendar year, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

I have read and understood this policy and accept the responsibility of its terms

Name of Patient

Signature

Date



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MEDICAL INFORMATION HIPAA RELEASE FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

RELEASE INFORMATION

I hereby authorize NAVIGATION MEDICAL CENTER, to release my protected health information: Medical information including, but not limited to diagnosis, procedures, treatment plans, appointments and test results and account and billing information, including, but not limited to account balances, payment and payment arrangements, insurance claim status and third party financing to the following person(s):

Spouse: _____ Date of Birth: _____

Child: _____ Date of Birth: _____

Child: _____ Date of Birth: _____

Other: _____ Date of Birth: _____

DO NOT DISCLOSED MY PROTECTED HEALTH INFORMATION TO ANYBODY

This release of information will remain in effect until terminated by me in writing.

MESSAGES:

Please call () my home phone number _____ () my cell number:

() my work phone number: _____ () other number: _____

The best time to reach me is: (day) _____ (time) _____

If unable to reach me, I acknowledge that medical and billing information may be left on voice mail, answering machine or with any person (s) identified in this form.

Signature of Patient or Legal Representative

Date of Authorization



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PATIENT PRIVACY STATEMENT – HIPAA 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. READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Use of Artificial Intelligence (AI) Tools: Our practice may use secure, HIPAA-compliant artificial intelligence (AI) tools to assist our staff and providers with administrative tasks and clinical documentation. These tools are used only to support patient care and operational efficiency.

All medical decisions, documentation review, and patient communications are overseen and finalized by qualified healthcare professionals. AI tools do not replace clinical judgment or decision-making. By signing this form, you acknowledge and consent to the use of AI-assisted tools as part of your care. If you have questions or concerns, please speak with our staff.



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YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice. We will notify you of such changes on the following appointment. We will make available copies of our new notice if you wish one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer.

Please sign this form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received our Notice of Privacy Practices.

PRINTED NAME

DATE OF BIRTH

SIGNATURE

DATE



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PAYMENT POLICY FORM

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in to the space provided. A copy will be provided to you upon request.

INSURANCE: We participate in most insurance plans. If you are not insured by the plan, payment in full is expected at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit may be required until coverage is checked and payment is received. Knowing your insurance benefits is your responsibility. Contact your insurance company to ask the questions you may have. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

CO-PAYMENTS AND DEDUCTIBLES: All co-payments, coinsurances, and deductibles must be paid at the time of service. This arrangement is part of your and our contract with your insurance company. Failure on our part to collect co-pays, coinsurances, or deductibles is considered fraud. Please help us in upholding the law by paying your copayment, coinsurances, and deductibles at each visit.

NON-COVERED SERVICES: Please be aware that some or all the services you receive may be uncovered necessary by your insurance. You must pay for these services.

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license or photo Identification card and current valid insurance. If you fail to provide information in a timely manner, you may be responsible for the balance of a claim.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

COVERAGE CHARGES: If your insurance changes, please notify us ASAP, so we can make the appropriate changes to help you receive maximum benefit. If claim is not paid in 45 days, balance will be billed to you.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please, be aware that if a balance remains unpaid, we will refer you to a collection agency and you and your immediate family members may be discharged from this practice. You will be notified by regular and certified mail that you have 30 days to find alternative medical care. In this period, our physicians will only be able to treat you on an emergency basis.



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MISSED APPOINTMENTS: We ask patients not to cancel or miss their appointment. But of course, there are situations patients need to call and cancel their appointment. Our policy allows patient to cancel without any penalty with at least 24 hours and with a live agent over the phone. Leaving message on Voicemail is NOT valid unless is done at +2 business days in advance. Failure to follow this policy will result in an inconvenience for you, other patients and our doctors. A \$50-fee will apply

I have read and understood the payment policy and agree to abide by its guidelines

| | | | |
|---------------------|----------------------|------------------|-------------|
| _____ | _____ | _____ | _____ |
| PRINTED NAME | DATE OF BIRTH | SIGNATURE | DATE |

DEBIT/CREDIT CARD AUTHORIZATION

I hereby authorize Navigation Medical Center to charge my debit/credit card for my on my dependent's future services not paid or not covered by the insurance company; that charge is based on the allowed amount determined by the insurance schedule fee. This authorization is intended only for medical services and cannot be used by other entities different than Navigation Medical Center. Navigation Medical Center is committed not to share credit card information with any other parties. Navigation Medical Center agrees to keep this information as strictly CONFIDENTIAL. This authorization remains in full force and effect until the last debit entry has been processed.

| | | | |
|---------------------|----------------------|------------------|-------------|
| _____ | _____ | _____ | _____ |
| PRINTED NAME | DATE OF BIRTH | SIGNATURE | DATE |