PATIENT INFORMATION

WELCOME PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT NAME _____ BIRTHDATE _____ AGE _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL _____

PATIENT EMPLOYER: _____ WORK PHONE # _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____ MARITAL STATUS _____ SOCIAL SECURITY _____

GENDER INFORMATION

GENDER _____ GENDER IDENTITY _____ PRONOUNS _____ SEXUAL OREINATION _____ SEX ASSIGNED AT BIRTH _____

GUARANTOR INFORMATION

GUARANTOR NAME _____ BIRTHDATE _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

SELF PAY o YES o NO GROUP# _____

I. PRIMARY MEDICAL INSURANCE CO _____ ID # _____

SUBSCRIBER NAME _____ BIRTHDATE _____ SS # _____

SUBSCRIBERS ADDRESS IF DIFFERENT FROM PATIENT _____

RELATIONSHIP TO PATIENT _____

SUBSCRIBERS EMPLOYER _____

II. SECONDARY MEDICAL INSUR CO _____ ID # _____

SECONDARY SUBSCRIBER NAME _____ BIRTHDATE _____ SS # _____

SECONDARY SUBSCRIBERS EMPLOYER _____

EMERGENCY NOTIFICATION INFORMATION

IN CASE OF EMERGENCY, PLEASE NOTIFY _____ RELATIONSHIP _____

HOME PHONE # _____ # OF EMERGENCY CONTACT: _____

INSURANCE CARD COPIED o YES o NO

☐ **I have verified the above information is correct, including all spelling of names, contact information and insurance/billing information**

Patient Notification Preference

Patient Referred by:_____

Primary Care Provider: _____

Do you have an Advanced Directive Yes☐ No ☐

Do you have a Medical Power of Attorney? Yes☐ No ☐

If for any reason, including test results (abnormal or normal) how would you prefer to be contacted by our office?
☐ Home Phone ☐ Cellphone ☐ Do Not Leave Message
☐ Leave Message

Facility Information:

Pharmacy Name:_____

Pharmacy Address/ Nearest Cross Street:_____

Lab:_____

Imaging Facility:_____

No-show ,Cancellation & Late Arrival Policy

Any time appointments are missed without a call for cancellation (no-show) within a 12 month period, the following policy will take effect: The first no-show will have no consequences. The second no-show will result in a letter to the patients address detailing the missed no-show appointments and reminder of our no-show policy. A third no-show will result in the patient being dismissed from practice/provider and a dismissal letter to the patient and PCP detailing the reason for dismissal. (remove anything regarding walk-in appointments please) .
Patients will be considered for discharge from BIG BEND HOSPITAL (RHC MCR & MCD & TRI) after 3 no- shows within a rolling 12 months.
In order to keep the clinic running smoothly and minimize wait times for patients, a late policy will take effect for any patient arriving more than 15 minutes beyond their appointment time. It is up to the providers discretion as to whether the patient can be seen or the need to reschedule, based on availability. No immediate appointments can be guaranteed, even with another providers.

Permission to Verbally Discuss Protected Health Information

I give my permission to VERBALLY discuss the following medical information about me (check all that apply):

- ☐ Medical Information (symptoms, diagnosis, medications and treatment plans)
- ☐ Lab and Test Results
- ☐ Billing
- ☐ Appointments
- ☐ Other (describe): _____

I understand that I have the right to revoke my permission at any time, except where the physician practice has already made disclosures in reliance upon this request. I understand that I must notify the physician practice in writing if I wish to revoke my permission. The physician practice has my permission to discuss the above information with the following:
☐ Do Not Release Information To Anyone

Name/Relationship to Patient: _____
Name/Relationship to Patient: _____
Name/Relationship to Patient: _____
Expiration Date or Event : _____

If Authorized Representative, please sign and attach copies of supporting legal documentation

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		

CONSENT

1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third- party, or proceeds of all claims resulting from the liability of a third-party, payable by any party, organization et cetera, to or for the patient unless the account for this Facility or series of outpatient visits are paid in full at the time of discharge or at the end of the series of outpatient visits. If eligible for Medicare, I request Medicare services and benefits, I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. **I understand that I am responsible for any charges not covered by my insurance company.**

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection. I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent to the facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

I understand it is my responsibility to present a valid I.D. and current insurance cards at each office visit and to inform the office of changes in insurance.

If my insurance requires a co-pay, I understand it is to be paid at time service. I understand that I am financially responsible for all non-covered services, deductibles and/or coinsurance.

If my insurance requires a referral, I understand it is my responsibility to obtain it and that it needs to be received before treatment to qualify for the maximum benefits from my insurance company.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

I have been made aware and understand that the medical practice and offices may use electronic prescription systems which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic system will be able to see information about medications I am already taking, including those prescribed by other providers. I give consent to my providers to see this protected health information.

3. NOTICE OF PRIVACY PRACTICE:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practice. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing and other types of treatment received.

4. GENERAL CONSENT FOR TEST, TREATMENT AND SERVICES:

I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my case in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care, or examinations in the Facility.

I have been informed of the treatment considered necessary for me that the treatments will be directed by a physician and may be performed by such a physician and/or one or more physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more of the physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment.

I understand that no guarantee or assurance has been made regarding (1) which physicians and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

5. CONSENT TO PHOTO/VIDEO:

I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released with protected health information regulations.

_____ (patient initials)

6. CONSENT TO PHOTOGRAPH AT THE TIME OF THE REGISTRATION:
☐ Yes ☐ No I, nor my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

7. PORTAL EMAIL:
☐ Yes ☐ No I consent to participate in the facility's Patient Portal and understand that my personal health and individually identifying information is made available to me in the portal. I understand I can see my test results and send messages to my provider. I understand I will be able to change my preference at any time. Email: _____

8. IMAGING SERVICES:
☐ Please check this box to allow the facility's imaging services to share your images with affiliated facilities. When requested for continuing medical treatment.

9. CELL PHONES:
☐ Yes ☐ No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice by texting or by emailing regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, schedule, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

Parent, Patient's Signature or Authorized Representative	Date	Time
Relationship to Patient	Interpreter, if utilized	
Witness' Signature		