

Demographic Information

Patient Name		Date of Birth	Sex Male / Female
Social Security Number	Email	Marital Status Single / Married / Widowed / Divorced / Other	
Mailing Address		City/State	Zip Code
Primary Phone	Secondary Phone	Work Phone	
I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers: <input type="checkbox"/> Primary Phone <input type="checkbox"/> Secondary Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Emergency Primary <input type="checkbox"/> Emergency Secondary			
Responsible Party <input type="checkbox"/> Self <input type="checkbox"/> Other – Information Below			
Name		Relationship to Patient	
Date of Birth	Primary Phone	Mailing Address [<input type="checkbox"/> Check if Same as Above]	
Employer's Name			
Emergency Contact	Emergency's Primary Phone	Emergency's Secondary Phone	
Pharmacy Name and Address		Pharmacy Phone Number	
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown		Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		Appointment Confirmation Preference <input type="checkbox"/> Email <input type="checkbox"/> Text	

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing
2.		<input type="checkbox"/> All <input type="checkbox"/> Scheduling <input type="checkbox"/> Medical <input type="checkbox"/> Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

 Signature of Patient/Legal Representative

 Date

Insurance Information

Primary	Secondary	Tertiary
Insurance Company	Insurance Company	Insurance Company
Name of Insured	Name of Insured	Name of Insured
Insured Date of Birth	Insured Date of Birth	Insured Date of Birth
Member ID/ Policy #	Member ID/ Policy #	Member ID/ Policy #
Group #	Group #	Group #

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our Patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. This offices' policy is to collect this co-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the Patients' share of the

medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the Patients' responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, or the parent or guardian with custody, for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by its' terms. I also understand and agree that the practice may amend such terms from time to time.

**I understand that payment for all services rendered is requested at the time of service.
We request a 24-hour cancellation notice of appointment or a \$25.00 fee will be charged for missed appointments.**

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed and/or have been given the opportunity to review this offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date

Prescription Policy

Our practice is a medical office that treats many types of ailments and conditions. On occasion we may prescribe medications for you to help relieve pain. These medications, when used properly, can help patients feel better and lead productive lives. These medications can also be misused, causing harm to patients and to others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulates use of these medications. Our practice follows those laws:

Our Policy:

1. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
2. Prescriptions are to be taken as directed. In other words, DO NOT change the frequency of the dose unless otherwise directed by your physician. If a change does occur, this will be documents in your chart.
3. By law, controlled substances cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office in the past three months, prescriptions for the following can not be refilled. Exceptions to this must be discussed with the physician during an office visit. Exceptions will not be granted over the phone.
 - a. Sleep Aids such as Ambien or Lunesta
 - b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
 - c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
 - d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will NOT be authorized at night, on weekends, or holidays. Be sure to plan ahead to make sure you have enough medication.
7. Before you visit our practice, please check your supply of medication. If you need refills please ask for them during your appointment.
8. Refill request for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled.
9. Refill request for prescriptions not prescribed by you physician will not be authorized.
10. At least 2 business days are needed for prescription request. Call before Friday.
11. Do not call more than once about a medication, refills, or any issue. When you call our office, a message is sent to your physician. Nothing can be done until you physician has a chance to review the message. The physician is the only one who can approve for your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to abide by this policy and understand that this signed policy will be scanned into my chart.

Printed Name of Patient

Date of Birth

Signature of Patient/Legal Representative

Date