Fort Bend Premier Care

Family Practice
New Patient Information Form

Date:_____ Appt with Dr._____

Name:_____ Date of birth:_____

Social Security #_____ Marital Status:_____

Physical Address:_____ Mailing Address:_____

_____ _____

_____ _____

Home phone number_____ Work phone number_____

Cell phone number_____

e-mail address:_____

Primary Insurance Company_____

Subscriber's Name:_____ Date of Birth:_____

SS#_____ Subscriber relationship_____

***Employer Name_____

Address:_____

_____

Subscriber/Member ID_____ Group #_____

**Preferred Pharmacy*_____ Phone:_____

Secondary Insurance Company_____

Subscriber's Name:_____ Date of Birth:_____

SS#_____ Subscriber relationship_____

Subscriber/Member ID_____ Group #_____

Please answer the following questions:

1.	Is this illness/injury covered by Worker's Compensation?	Yes	No
2.	Is this illness/injury due to an automobile accident?	Yes	No
3.	Is the patient age over 65?	Yes	No
4.	Is this patient or the patient's spouse employed by an employer of 20 or more employees?	Yes	No

SIGNATURE:

_____

How were you referred to us? (Please check one)

a. Physician _____ Physician Name_____
b. Friend _____
c. Family _____
d. Hospital _____
e. Newspaper _____
f. Other _____

Emergency Contact : (Closest relative/friend NOT living with you – or a different number than your home number)

NAME: _____

Relationship: _____

Home Phone Number: _____

Cell Phone Number: _____

PLEASE SIGN ALL THREE AREAS:

Benefits Assignment: I authorize payment of medical benefits to Fort Bend Premier Care for all medical services rendered. I also request payment of governmental benefits to the party who accepts claim assignment.

_____
Patient or authorized person's signature **Date**

Medical Records Release: I authorize the physician rendering care, treatment, and / or services to release any medical documentation information necessary to process my insurance claims for purposes of benefit payment.

_____
Patient or authorized person's signature **Date**

Consent for Treatment: I hereby agree and give consent for medical treatment under the care of Fort Bend Premier Care.

_____
Patient or authorized person's signature **Date**

OFFICE FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. In order to keep our fees to a minimum we **require** that you pay at the time of service so that we do not have to send bills. We may order laboratory tests, perform office procedures or diagnostic tests as part of our comprehensive evaluation. Payment for these services is due and payable at the time of service. In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

Self-Pay
FULL PAYMENT FOR PROFESSIONAL SERVICES ARE DUE AT THE TIME OF SERVICE.
We accept cash, checks, debit/ATM cards, Visa, MasterCard, and American Express.

Insurance
PAYMENT OF COPAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be denied if the payment is not made at check-in. Our office will file an insurance claim for services rendered, but ultimately you are responsible for the bill. **By law your insurance company must remit payment or deny your insurance claim within 30 days of initial notice. If your insurance company has not paid your account in full within 45 days we may ask for your assistance in getting your insurance company to pay the balance or the balance may be billed to you. We file claims to your insurance company but your insurance policy is a contract between you and your insurance company. We are not a party to that contract and so your balance will be due immediately. _____(please initial)**

Insurance Coverage Changes
In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for payment of all fees for the service rendered. We will file insurance claims immediately for all these services, if requested, and reimbursement from the insurance company should be made directly to you. Again, if this office receives payment, a check will be issued to you within 30 days for reimbursement. We ask that you participate in any disputes with your insurance company regarding your policy guidelines and insurance payments.

Financial Responsibility for Minors
Unless prior arrangements have been made, charges for a minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Returned Checks
Returned checks are subject to a **$45.00** charge and returned checks older than 30 days may be subject to an additional **$50.00** charge. Returned checks may be referred to the District Attorney for legal action in some cases.

As we stated above, the primary goal of our practice is to provide the finest medical care and services to the people in our community. Since our practice also has financial obligations which must be met, we ask that all patients pay for their examinations and treatment in full on the day of each visit to our office. In regards to insurance plans where we are a participating provider, all copays and deductibles are due prior to treatment. **You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone number, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide us. _____(please initial)**

I have read, understand and agree to abide by the financial policy set forth.

I acknowledge that I have received a copy of **Fort Bend Premier Care office's Notice of Privacy Practices.**_____ (initial)

_____ _____
Signature of Patient/Responsible Party **Date**

_____ _____
Witness signature **Date**

Premier FORT BEND CARE

TO WHOM IT MAY CONCERN:

I, _____ Date of Birth _____
do hereby authorize the release of my Medical Records, Billing information, and Health Information to the following individuals:

_____ _____
Name Relationship

_____
Phone Number

_____ _____
Name Relationship

_____
Phone Number

_____ _____
Name Relationship

_____
Phone Number

This release shall be valid until I revoke it in writing.

Authorized by: _____
(Printed name)

_____
(Signature)

Date: _____

1505Liberty St., Richmond, TX 77469 TE: 281-342-9500 FAX: 281-342-6667

FORT BEND PREMIER CARE

Family Practice

Dear Patient,

The Referral that your Doctor has requested, or that is required by your insurance company has just been initiated. We request your cooperation in order for this process to be completed efficiently, for both you and for our office staff. We will make every effort to complete this process as quickly as possible. However, due to the different insurance referral processes, and the daily work flow of office patients, please allow 5-7 days for completion of this process.

We will notify you when the referral is complete. We request that you ***do not make appointments with any other office, lab, or x-ray department until your referral is complete.*** The referral nurse or your physicians' nurse will fax, call, or send required referral information when it is necessary to do so.

WHAT THE REFERRAL PROCESS INVOLVES:

- Filling out necessary forms
- Obtaining correct coding information for your referral
- E-mails, phone calls and/or fax's to and from your insurance company
- Phone calls to and from Provider offices
- Locating your in-network provider
- Waiting for authorization from your insurance carrier
- Sending, faxing, calling information
- Patient notification
- At times, scheduling appointments

Thank you for your cooperation.

Nursing/Referral Staff

FORT BEND PREMIER CARE

1505 Liberty Street
Richmond, TX 77469

Effective Date: August 1, 2006

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.

1. **Purpose:** The FORT BEND PREMIER CARE (FBPC) office and its professional staff, employees, and volunteers and all of its affiliated entities follow the privacy practices described in this Notice. The FBPC office maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, the FBPC office must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, the FBPC office must share your medical information as necessary for treatment, payment, and health care operations.

2. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medications, or with radiologists or other consultants in order to make a diagnosis. The FBPC office may use your medical information as required by your insurer or HMO to obtain payment for your treatment. We also may use and disclose your medical information to improve the quality of care, *e.g.*, for review and training purposes.

3. **How Will The Fort Bend Premier Care Office Use My Medical Information?** Your medical information may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

   - Religious affiliation to a chaplain or member of the clergy.
   - Family members or close friends involved in your care or payment for your treatment.
   - Disaster relief agency if you are involved in a disaster relief effort.
   - Appointment reminders.
   - To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
   - As required by law.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
   - Health oversight activities, *e.g.*, audits, inspections, investigations, and licensure.
   - Lawsuits and disputes.
   - Law enforcement (*e.g.*, in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the Facility's premises; and in emergency circumstances relating to reporting information about a crime.)
   - Coroners, medical examiners, and funeral directors.
   - Organ and tissue donation.
   - Certain research projects.
   - To prevent a serious threat to health and safety.
   - To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
   - National security and intelligence activities.
   - Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
   - Inmates. (Medical information about inmates of correctional institutions may be released to the institution.)
   - Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
   - To carry out health care treatment, payment, and operations functions through business associates, *e.g.*, to install a new computer system.

4. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize (permit) the FBPC office in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

5. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to chosen healthcare providers' office or to Fort Bend Premier Care, Attn: Practice Manager, 1505 Liberty Street, Richmond, Texas 77469

   - **Right to request restriction.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (*e.g.*, you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
   - **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care; however, psychotherapy notes may not be inspected or copied. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the Facility. The Facility will comply with the outcome of the review.
   - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the Facility, which requires certain specific information. The Facility is not required to accept the amendment.
   - **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment, payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.
   - **Right to a copy of the Notice.** You may request a paper copy of the Notice at any time.

6. **Requirements Regarding This Notice.** FBPC's office is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. FBPC's office may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at FBPC's office facility for health care services, you may receive a copy of the Notice in effect at the time.

7. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Fort Bend Premier Care office or with the Secretary of the United States Department of Health and Human Services. *You will not be penalized or retaliated against in any way for making a complaint to the Facility or the Department of Health and Human Services.*

Contact: Call Fort Bend Premier Care's office at 281-342-9500 – Contact the Practice Manager if:

- **You have a complaint.**
- **You have any questions about this Notice.**