REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION

Patient's last name: First: Middle:			Marital status (circle one) Single / Mar / Div / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Maiden name:	Birth date: / /	Sex: ❑ M ❑ F
Street address:		Social Security no.:	Phone no.: ( )	
City:	State:		Zip Code:	
Email:				
Occupation:	Employer:		Employer phone no.: ( )	
Preferred Pharmacy:				

PARENT/GUARDIAN INFORMATION

Name:	Birth date: / /	Address (if different):	Phone no.: ( )
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the healthcare provider. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. I authorized Your Healthcare to contact me by phone, email and/or text. Your Healthcare may obtain my historical prescriptions electronically. I am aware I may revoke these authorizations at anytime by written notification to Your Healthcare.

SIGNATURE

Name: Date:

2100 W White St, Ste 150
Anna, TX 75409
972-587-6080

Your Healthcare

PATIENT INFORMATION SHEET

NAME: _____ **SEX: M / F** **DOB:** _____ **DATE:** _____

DRUG ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

PERSONAL MEDICAL HISTORY: (Please circle all that apply)
Up to date on Immunizations (YES / NO)
(adult) Date of last tetanus:_____

ADHD	Allergies, Seasonal	Diabetes: 1 or 2	GERD (|Acid Reflux)
Anxiety	Asthma	High Blood Pressure	Hiatal Hernia
Depression	COPD/Emphysema	High Cholesterol	Irritable Bowel Syndrome
Bipolar	Sleep Apnea	Heart Attack	Gastric Ulcer
Dementia	Osteoporosis	Heart Disease	Crohn's Disease
Migraines	Osteoarthritis	Bleeding Problems	Ulcerative Colitis
Rheumatoid Arthritis	Anemia	Diverticulitis	Peripheral Vascular Disease
Neuropathy	Gout	DVT (blood clot)	Liver Disease
Stroke	Thyroid Disorder	Kidney Disease	Hepatitis
Seizure Disorder	Psoriasis	Kidney Stones	HIV
Bladder Problems / Incontinence		Arrhythmia (irregular heart beat)	

Cancer: _____

Other medical problems not listed above: _____

Colonoscopy Yes/No Date: _____ Normal / Abnormal

WOMEN:
Last Menstrual Period Date: _____ Normal / Abnormal
Pap Smear Yes/No Date: _____ Normal / Abnormal
Mammogram Yes/No Date: _____ Normal / Abnormal
Form of Birthcontrol:_____

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Your Healthcare

Surgical History: Please list all prior surgeries and approximate dates performed.

Date	Surgery

SOCIAL / CULTURAL HISTORY:

Education Completed: ☐ Elementary ☐ High School ☐ 2yr College ☐ 4yr University ☐ Masters ☐ PHD / MD

Nicotine Use: ☐ Current ☐ Past ☐ Never **Type**: _____ **Amount/day**: _____ **# of Years total**: _____

Alcohol: Number of drinks per week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol
Osteoporosis	Anemia	Cancer: _____	Diabetes 1 or 2
High Blood Pressure	Stroke	Asthma	COPD/Emphysema
DVT (Blood Clot)	Kidney Disease	Thyroid Disorder	Arthritis
Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol
Osteoporosis	Anemia	Cancer: _____	Diabetes 1 or 2
High Blood Pressure	Stroke	Asthma	COPD/Emphysema
DVT (Blood Clot)	Kidney Disease	Thyroid Disorder	Arthritis
Dementia	Heart Disease	Migraines	

Other: _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

Patient Signature: _____ Date: _____

(parent or guardian signature if pt is a minor)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATIONS

Privacy Practices:
I have reviewed Y.H. Anna, PLLC / Your Healthcare's 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 this notice if requested. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

_____Initial

Authorizations:
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

I authorize Y.H. Anna, PLLC / Your Healthcare, to release to my insurance provider any information required, including the diagnosis and recommended course of my examination or treatment.

I understand it is the patient's responsibility to let Y.H. Anna, PLLC / Your Healthcare, to know if Pre-Certification is required for any office visit, Radiological procedures, specialty referrals and any surgeries.

I understand that failure to notify this office may cause me increased out-of-pocket expenses such as denies claims and reduced benefits.

I authorize payment directly to Y.H. Anna, PLLC / Your Healthcare, for the medical and/or surgical benefits otherwise payable to me, for services to me. I understand that I am financially responsible for the charges not covered by my insurance.

_____Initial

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my healthcare provider or his/her designees, determines to be necessary.

_____Initial

_____ _____ _____
Patient Name (Print) Patient Signature Date

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____
Personal Representative (Print) Personal Representative Signature

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GENERAL INFORMATION-PLEASE READ

In an effort to avoid any confusion, we would like to provide the following information. It is our hope that this will answer most of the questions or concerns you may have regarding our financial policies. If you have additional questions, please do not hesitate to ask. If you would like a copy of this form, please ask at the front desk.

Payment *IS DUE ON THE DAY OF SERVICE*. Please be prepared to pay on the day of service. We accept cash, Visa, MasterCard, Discover, and American Express.

CREDIT CARD ON FILE. To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills we will require all patients keep an active credit card on file with us. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to: missed or canceled appointments without 24-hour notice, missed co-payments, deductible and/or co-insurance, any non-covered services and/or denial of services.

INSURANCE: We will file insurance as a courtesy to our patients. We make no guarantee of coverage by insurance but will verify insurance benefits. The portion of the treatment not estimated to be covered by the primary insurance is due on the day of service. If insurance has not paid after 60 days from the date of service, the balance becomes the responsibility of the patient. If you have any questions or concerns regarding your coverage, please contact your insurance carrier directly. If you need to know what your insurance will cover for a specific procedure, we can file a pre-treatment estimate. *ANY PORTION NOT COVERED BY INSURANCE IS THE RESPONSIBILITY OF THE PATIENT.* If you do not have your insurance information with you, payment will be due in full.

Medicaid/Medicare: WE DO NOT FILE WITH MEDICAID OR MEDICARE. IF YOU CHOOSE TO BE TREATED, YOU CAN NOT SUBMIT CLAIMS FOR REIMBURSMENT TO MEDICARE.

RETURNED CHECKS: THERE IS A $30.00 FEE FOR A RETURNED CHECK. If a person has a returned checks, we will no longer accept personal checks. Payment must be made by cash, credit card or certified funds.

BROKEN/MISSED APPOINTMENTS: In order to provide the best possible service and availability to all our patients, we reserve the right to charge for missed/cancelled appointments (less than 24-hour notice). Monday appointments must be cancelled by close of business on the prior Friday to avoid being subject to the fee. Please call us as early as possible to reschedule your appointment. If a patient has two or more broken appointments in a six-month period, we will not be able to schedule any further appointments. The fee for missing or canceling an appointment with less than a 24-hour notice is $40. If you arrive more than 10 minutes late, your appointment may have to be rescheduled. We will make every attempt to keep your appointment, but feel we must be fair to the next person scheduled.

PAST DUE ACCOUNTS: When an account is over 90 days past due, it will be turned over to a collection agency. The patient will be placed in a "dismissed" status until the balance, including any fees, is paid in full. Once the balance is paid, payment will be due in full on the day of service for all future appointments and we will no longer accept insurance assignment.

THIRD PARTY ACTION: If third party action becomes necessary, the financially responsible party agrees to pay for all collection fees to include: 30% collection agency fee, court costs, and attorney fees.

SIGN BELOW INDICATING YOU HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS

Signature_____Date_____

PLEASE NOTE: WE RESERVE THE RIGHT TO CHANGE ANY OF THE ABOVE WITHOUT NOTICE

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