[CLINICS NAME] ■ [STREET ADDRESS] ■ [CITY STATE ZIP] ■ [PHONE NUMBER]

PATIENT INFORMATION:

First Name:_____ Last Name:_____

Date of Birth:_____ Age: _____ Sex: ☐ Male ☐ Female

SS#:_____ Phone#: _____

Permanent address

Address:_____ City:_____ State: _____ Zip:_____

Billing address ☐ *SAME AS ABOVE*

Address:_____ City:_____ State: _____ Zip:_____

GUARANTOR INFORMATION: Mother

First Name:_____ Middle Name:_____ Last Name:_____

Permanent address ☐ *SAME AS PATIENT ADDRESS*

Address:_____ City:_____ State: _____ Zip:_____

Billing address ☐ *SAME AS ABOVE*

Address:_____ City:_____ State: _____ Zip:_____

Home Phone number: _____ Cell Phone number: _____

GUARANTOR INFORMATION: Father

First Name:_____ Middle Name:_____ Last Name:_____

Permanent address ☐ *SAME AS PATIENT ADDRESS*

Address:_____ City:_____ State: _____ Zip:_____

Billing address ☐ *SAME AS ABOVE*

Address:_____ City:_____ State: _____ Zip:_____

Home Phone number:_____ Cell Phone number: _____

EMERGENCY CONTACT: (PLEASE NOTE TWO EMERGENCY CONTACTS)

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number:_____ Relationship: _____

I do herby consent for any medical procedures deemed necessary by the clinician at this office. I understand that my insurance is considered a method of reimbursement for services provided to me. It is my responsibility to pay insurance co-pays, co-insurance and deductible amounts applied by my insurance. I hereby authorize the clinic to release any information necessary to review and process my claims for payment. I further agree that a photocopy of this agreement shall be valid as the original. I, _____ **Parent/Legal guardian/Guarantor Name** with date of birth _____ want my child to be treated by [CLINICS NAME]. I am the patient's parent, legal guardian or guarantor and have the right to make medical decisions for the patient _____ **Patients Name** with date of birth _____ and I assume the financial obligation of another party in the event that the original party/Insurance is unable to fulfill their obligation.

Guarantor Signature: _____ DATE:_____

RE PATIENTS NAME: _____ **DOB:**_____

MEDICAL INSURANCE

☐ *SELF PAY/ PRIVATE PAY/ NO INSURANCE*

PRIMARY	
Insurance Name:	
ID:	
Insured Name:	
Insured DOB:	
Relationship to patient:	

☐ *SECONDARY INSURANCE NOT APPLICABLE*

SECONDARY	
Insurance Name:	
ID:	
Insured Name:	
Insured DOB:	
Relationship to patient:	

I understand the payment for services rendered by **[CLINICS NAME]** and staff is expected at the time of services, unless arrangements are made in advance with the front office clerk, such as through insurance/Medicaid. I also understand that it is my responsibility to pay for any incurred services as a result of not notifying any changes with my insurance. I understand that it is my responsibility to bring my insurance card and ID to each visit and to notify us of any changes and to make sure that the provider is in-network with my current insurance plan, failure to do so may result in me being financially responsible for any charges occurred at the time of service.

RELEASE OF INFORMATION: I authorize **[CLINICS NAME]** to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (an estimated amount on coinsurances and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I am aware that because only an estimated amount may be collected in reference to coinsurance and or deductible it can result in a credit(s)/balance due for the services rendered at the time of visit. I understand if any other additional services are rendered at the time of service, other than an office visit amounts paid at the time of service, that I must check out with front office/check out clerk and aware them of any additional services that were rendered and if any other additional amounts are owed. I am also made aware that I am able to check directly with my insurance thru member services or my online member portal in regard to status of my medical claims and see if any balance will be owed. I understand that any amounts less than $15 will be applied towards my next office visit.

MEDICAID RESPONSIBILITY: I understand that **[CLINICS NAME]** is accepting me with the insurance mentioned above, if at any time I become eligible with Medicaid I will notify the clinic right away. I understand that **[CLINICS NAME]** does not accept Medicaid outside of Texas therefore I will be fully responsible for any fees incurred during my visit unless I have a private or commercial insurance that is in-network with the practice.

PRIVATE PAY AGREEMENT: I understand **[CLINICS NAME]** is accepting me as a private pay patient, and I will be responsible for paying for any services I receive at the time of service. The provider will not file a claim to Medicaid or any other insurance for services provided to me.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Patient/Responsible Party Signature: _____

Date: _____

RE PATIENTS NAME: _____ **DOB:**_____

AKNOWLEDGEMENT OF REVIEW OF NOTICE OR PRIVACY PRACTICE

I , have reviewed **[CLINICS NAME]**notices of Privacy Practices, which explain how my medical information will be used and disclosed. I have been given the opportunity to ask question if I do not understand.

I understand that I am entitled to receive a copy of this document _____ [INITALS]

I understand that, in a routine medical situation, **[CLINICS NAME]**will not release any of my Protected Health Information (PHI) to my family, caregiver, Husband, or friend(s) without the expressed written consent from me, the patient, power or attorney, or in the case or a minor, parent/legal guardian. (PLEASE CHECK ONE)

_____ YES, I GIVE CONSENT TO RELEASE THE PROTECTED HEALTH INFORMATION OF THE PATIENT NAMED ON THIS FORM TO THE SPEFICIED INDIVUDIAL(S) SHOWN BELOW DESIGNATED BY ME:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

_____ NO, MY PROTECTED HEALTH INFORMATION OF PATIENT NAMED ON THIS FORM MAY NOT BE RELEASED TO ANYONE

Patient Name:_____ DOB:_____

Patient/ Guarantor Signature: _____ Date_____

PERMISSION TO CONTACT YOU

I give permission to **[CLINICS NAME]**to contact me or leave voicemail when I am unavailable via: PLEASE CHECK ONE OR ALL THAT APPLY

☐ E-mail: _____

☐ Home Phone Number: _____

☐ Cell Phone Number: _____

By signing below you indicate that you give us permission to contact you at the above method and you allow us to leave a voice message and or send an email.

_____ _____

Patient/ Guarantor Signature Date

RE PATIENTS NAME: _____ DOB:_____

Patient Consent and Acknowledgement of Receipt of Privacy Notice (HIPAA)

I understand that as part of the provision of healthcare services, **[CLINICS NAME]** creates and maintains health records and other information describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment.

I can be provided with a Notice Of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that **[CLINICS NAME]** reserves the right to change their Notice and practices prior to implementation and will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for discretionary purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting, or arranging for medical review, legal services and auditing functions, etc.) and that **[CLINICS NAME]** is not required to agree to the restrictions requested.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. **[CLINICS NAME]** is authorized to disclose patient health information to insurance companies, referring physicians for the purposes of requesting doctor's orders, authorization for service, or to obtain reimbursement for services. Information may be sent via first class mail or fax with procedures in place to limit the likelihood of unauthorized access. The date sent will be documented by the responsible office personal.
4. I have had the right to request that the use of my protected health information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that **[CLINICS NAME]** and I must; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

My signature below indicates I have received and acknowledge that I have read **[CLINICS NAME]** notice of privacy practices

_____ _____

Patient/ Guarantor Signature Date

PHYSICIAN ASSITANT/ NURSE PRACTINIONER
CONSENT FOR TREATMENT

This facility has on staff a Physician Assistant/Nurse Practitioner to assist in the delivery of medical care.

A Physician Assistant/Nurse Practitioner is not a doctor. A Physician Assistant/Nurse Practitioner is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a Physician Assistant/Nurse Practitioner can diagnose, treat and monitor common acute and chronic disease as well as provide health maintenance care. "Supervision" does not require the constant physician presence of the supervising physician, but rather overseeing the activities of accepting responsibility of the medical service provided.

A Physician Assistant/Nurse Practitioner may provide such medical services that are within his/her education, training and experience. These may include:

- Obtaining Histories and performing physician exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

By signing below you indicate that you have read above and give consent to the services of a Physician Assistant/Nurse Practitioner for your health care needs. That you understand that at any time you can refuse to see the Physician Assistant/Nurse Practitioner and request to see a physician. And that you agree to all the condition and terms within all of the 5 previous consent forms listed above.

Patient/ Guarantor Signature: _____ DATE:_____

OFFICE POLICIES

[CLINICS NAME] & staff appreciate the confidence you have shown in choosing us to provide for your medical needs. Our office strives to provide quality and timely healthcare for your child as well as thousands of other families in the area. Our staff works very hard to provide flexibility in the scheduling of appointments so that they maintain availability of our healthcare providers to see your child as promptly as possible. Our office see's patients of all ages. Please read our policies below

Appointments & Walk-Ins: We accept walk-ins during our business hours but please note that we will give priority to our patients that have scheduled appointments, it is the office policy to verify your insurance eligibility and benefits each time you come in. This process is time consuming and out of our control. We apologize for any inconvenience this may cause. For this reason we recommend you to have an appointment schedule with is so that we may verify your insurance the day before. We have appointments for the same day but it is recommended you call in the morning. Once again we do accept walk-ins during our regular business hours but there could be a waiting time.

Prescriptions and Prior Authorizations: Please note that if you haven't been here in the last 3 months, refill on prescriptions will not be allowed. It is state mandatory that the patient follows up with their provider every three months (*Restrictions and limitations may apply to certain medication like pain killers and such). If you have been here in our office within the last 3 months please call your refill in 24 hours before you run out. Our office can take up to 24 hours to approve your refill medication. Prior Authorization for medication/procedures not covered or in need of an authorization will be completed as we receive them. Prior Authorization takes between 24-48 hours to complete from the time they have been received. Please understand that and insurance policy is a contract between and insurance company and you. Or office will do its best effort to help you get your services approved and paid but ultimately the patient is responsible for any unpaid amounts by your insurance. The office does not have any control on how long your insurance takes to approve any treatments and/or medications.

Other Procedures: **Please bring ALL your current medication to every appointment.** Our office will not refund any payment once you have been seen by **[CLINICS NAME]** unless otherwise specified by your insurance, for this reason it is important you let our front office receptionist know the reason you are here to avoid any misunderstandings.

Medical Records/Paper work to be filled out: Please note that because of our busy schedule we may not be able to fill out paper work or print your medical records immediately. **[CLINICS NAME]** will make its best efforts to have it medical records ready within 15 business days after your request has been received. Please note that there is a fee for any lost immunizations card of $5.00 and for Medical Records there is a fee of $25.00 for the first 25 pages, and $0.50 for each page thereafter, along with a reasonable fee for the actual cost of mailing, shipping or delivery. Most paper work to be filled out takes between 24-48 hours to be completed and all paperwork has a fee of $25. Please note that the application for persons with disability parking placecard/license plate takes 2-3 weeks to be filled out along with any others forms that requires for our supervising doctor to fill this out.

Please keep in mind that order such as Title 19, personal care services, and/or any forms that are required to be filled out or need physician signature, will not be signed unless the patient has been seen in our office in the last 3 months and the patient must be up-to-date with their Texas Health Steps Physical

Referrals to Specialist: Our provider may need to refer you to a specialist or another doctor. **[CLINICS NAME]** will make the first appointment for you and we will notify you of this appointment and provide you with your referral that you are required to take with you to your doctor's visit. If you miss your first appointment or you're unable to make the first appointment it is the patient's responsibility to re-schedule and set the appointment for a later date.

Minor Patients: All patients under the age of 17 MUST bring their vaccination cards at ALL time whether if the patient is coming in sick or if the patient is coming in for a physical. All minor patients (17 and younger) must be accompanied by a parents unless we have a letter from parent allowing and approving the adult to make any medical decisions for the child. This letter must be signed by the parent and a photocopy of the parents ID must be provided with the letter. The adult accompanying the minor patient will be require to bring in their ID as well.

Responsible Party: A responsible party is **the person who is responsible for paying the patient's account bills,** the person who will be financially responsible for the account. If the patient is 18 and older, then responsible party is Self.

Patients Name: _____ DOB: _____

Responsible Party Name: _____ DOB: _____

Patient/ Responsible Party Signature: _____ DATE:_____

_____ ***INITIALS OF PERSONELL WHO PROVIDED A COPY OFFICE POLICY TO PATIENT***

Financial Policy

If our office has a contract with your insurance carrier we are ***required by law*** to collect all co-pays, deductibles and co-insurances. Our office will NOT waive your co-pay deductible and/or co-insurance as this will breach our contract with your insurance carrier. Our office will not refund any payment once you have been seen by our nurse practitioner, PA or Doctor; **[CLINICS NAME]** unless otherwise specified by your insurance, for this reason it is important you let our front office receptionist know the reason you are here in order to avoid any misunderstandings. All co-pays, deductible and/or co-insurance and self-pay monies will be due at the time of visit before seeing the provider. Any remaining balance for self-pay patients will be paid at the check-out window. Please be advised that our Nurse Practitioner, PA and Doctors are NOT allowed to discuss your financial account. Please direct your questions to our billing department.

[CLINICS NAME] is authorized to disclose patient health information to insurance companies, All Medical Billing & Consultants, LLC which **[CLINICS NAME]** uses as an outside medical billing agency or referring physicians for the purposes of requesting doctor's orders, authorization for service, or to obtain reimbursement for services. Information may be sent via first class mail, fax or electronically with procedures in place to limit the likelihood of unauthorized access. The date sent will be documented by the responsible office personal

We accept the following for payment: cash, debit cards, Visa & Master Card. Payment is expected in full at the time of visit. In some cases, we may have a contract with your insurance company governing how we handle your account. This contract may prevent us from offering a *time of service* discount.

Insurance coverage is never a guarantee payment If at any given time your insurance is terminated and/or your insurance does not pay for service rendered you will have to pay out of your pocket for anything that is not covered by the insurance unless the service is covered under a contractual agreement between **[CLINICS NAME]** and your insurance carrier. Your insurance company determines benefits once they receive our billings. Any statement made by our staff regarding your coverage in no way or guarantees that your care here will be covered by your insurance company, and you will be responsible for your account, regardless of your insurance.

In order to ensure insurance benefit coverage for any services rendered, it is imperative that the patient provide a current insurance card at each office visit. If insurance verification and coverage cannot be determined prior to the visit, payment will be requested at the time of service. Failure to provide most recent insurance card or correct insurance information may result in patient/responsible party be bill in full for services rendered. Please be advised the eligibility and benefit information supplied by your insurance company is only an estimate and is not a guarantee of payment by the insurer. Actual benefits are subjected to all plan, terms, definitions, conditions, limitation and exclusion under the member's policy, including the patient's effective status on the actual date of service. **[CLINICS NAME]** along with All Medical Billing & Consultants, LLC will submit your bill to your insurance company for services performed by our medical providers; however, it is ultimately the patient's responsibility to pay for any and all services provided. State law requires that insurance companies pay most claims within 45 days of submission. If there is difficult processing any claim(s) submitted, we may ask for your assistance working with your health care plan provider. It is very important that you respond promptly to any inquiries from your insurance company since failing to do so could result in delay or denial of claim coverage.

You may have a credit balance on your account after your insurance process payment for your visit. This would occur if you overpaid your deductible and/or co-insurance. By singing below you area allowing for us to retain any amount less than $15.00 to be applied to future visit or service payments.

[CLINICS NAME] is not responsible for verifying benefits for hospital, anesthesia or any other outside service or facilities. We will ask if the facility or clinic we are referring you if they are in-network with your plan.

Private Pay: Payment is due for the office visit in the front. New Patient fee for consultation is $70 & for establish patients it is $60 please note this is the consultation only & does not include any additional lab or procedures done in the back with provider or nurses. Before anything is done, please ask the Medical Assistant assisting you how much will it be for any additional labs or procedures **BEFORE** services are rendered so that you may have an idea the cost of additional service. If at any given point if it does become very high for you, our provider understands this and we want to put your health first so therefore we will offer payment plans. Please ask one of our front office receptionist or billing department about this payment plans. **Restrictions and limitations may apply*

Responsible Party: A responsible party is **the person who is responsible for paying the patient's account bills,** the person who will be financially responsible for the account. If the patient is 18 and older, then responsible party is Self.

Please feel free to ask billing department of any financial questions you may have. Our intent is to provide you with the highest level of service of well care.

Patients Name: _____ DOB: _____

Responsible Party Name: _____ DOB: _____

Patient/ Responsible Party Signature: _____ DATE: _____

_____ ***INITIALS OF PERSONELL WHO PROVIDED A COPY FINANCIAL POLICY TO PATIENT***