Moore County Bone & Joint
Renee Riley, M.D. | James Warrilow, PA-C | Trisha Agle, PA-C
1515 E 1st St, Suite 200, Dumas, TX 79029
PHONE (806) 935-4535 | FAX (806) 935-7178

PATIENT REGISTRATION PACKET

The person filling out this paperwork is: The Patient ☐ The Patient's Guardian ☐

PLEASE FILL OUT THE FOLLOWING SECTION WITH THE PATIENT'S INFORMATION

First Name | Middle Name | Last Name

Mailing Address | City | State | Zip

Cell Phone | Alternate Phone | Biological Sex: MALE ☐ FEMALE ☐

Email Address | May we contact you via email (test results by phone call): YES ☐ NO ☐

Date of Birth | SSN | Primary Care Physician | Age

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ | Preferred Pharmacy

Emergency Contact Information

First Name | Last Name | Address

Phone | Relationship to Patient

Additional Emergency Contact not living in same home as patient

First Name | Last Name | Address

Phone | Relationship to Patient

PLEASE FILL OUT THE FOLLOWING SECTION IF YOU ARE THE PATIENT'S GUARDIAN

First Name | Middle Name | Last Name

Mailing Address | City | State | Zip

Cell Phone | Alternate Phone | Date of Birth | SSN

Place of Employment | Relationship to Patient

Revised 02.01.2024

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PRIMARY INSURANCE INFORMATION

Name of Person with Insurance (Insured)	Insured Date of Birth
Name of Insurance Company/ Policy	Insured Employer
Insured SSN	Insured Relationship to Patient

SECONDARY INSURANCE INFORMATION (if applicable)

Name of Insured	Insured Date of Birth
Name of Insurance Company / Policy	Insured Employer
Insured SSN	Insured Relationship to Patient

BY SIGNING AND DATING BELOW, I ATTEST THAT THE PATIENT INFORMATION, GUARDIAN INFORMATION, AND INSURANCE INFORMATION PROVIDED BY ME ARE ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature

CONSENT TO TREATMENT

I HEREBY VOLUNTARILY CONSENT TO THE CARE PROVIDED BY THE MEDICAL STAFF ASSOCIATED WITH THIS CLINIC ENCOMPLASSING DIAGNOSTIC PROCEDURES, EXAMINATIONS, MEDICAL/ SURGICAL TREATMENT, OR CLINICAL SERVICES PRESCRIBED BY THE MEDICAL STAFF, THEIR ASSISTANTS, OR THEIR DESIGNEES AS IS NECESSARY IN THE MEDICAL STAFF'S JUDGMENT. IN THE INSTANCE THAT I AM THE GUARDIAN OF THE PATIENT: FOR THE ABOVE-NAMED PATIENT, I AUTHORIZE THIS CLINIC'S MEDICAL STAFF TO PROVIDE MEDICAL, DENTAL, VISION, AND/OR EMERGENCY TREATMENT TO MY WARD. I UNDERSTAND THAT THIS AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT.

RELEASE OF INFORMATION: I AUTHORIZE THIS CLINIC TO RELEASE MEDICAL INFORMATION TO THIRD-PARTY CARRIERS FOR THE PURPOSE OF FILING INSURANCE CLAIMS RELATED TO MY/MY WARD'S MEDICAL CARE. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ABOUT TREATMENT TO MY/ MY WARD'S DOCTOR OR ANY DOCTOR DESIGNATED BY ME.

FINANCIAL AGREEMENT: I AGREE TO BE FINANCIALLY RESPONSIBLE AND TO PAY THE COST OF THE SERVICES RENDERED TO ME/ MY WARD TO THE ACCOUNT OF THIS CLINIC IN ACCORDANCE WITH THE REGULAR RATE AND TERMS OF THIS CLINIC.

I UNDERSTAND THAT THIS FORM WILL BE VALID AND REMAIN IN EFFECT FOR ONE CALENDAR YEAR. THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I UNDERSTAND ITS CONTENTS.

Signature

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CONSENT FOR VIRTUAL MEDICAL SCRIBE

OUR MICROPHONE-EQUIPPED EXAM ROOMS ALLOW VIRTUAL MEDICAL SCRIBE ASSISTANTS TO LISTEN AND TRANSCRIBE YOUR VISIT INTO OUR ELECTRONIC MEDICAL RECORDS CHARTING SYSTEM. THIS COURTESY SERVICE PROVIDES YOU A MORE ACCURATE RECORD QUICKLY AND HELPS THE DOCTOR FOCUS ON THE PATIENT'S WELL-BEING.

THE PHYSICIAN COULD MAKE AN AUDIO RECORDING OF THE VISIT FOR QUALITY- CONTROL PURPOSES AND ACCURATE DATA ENTRY INTO THE PERMANENT MEDICAL RECORD, THOUGH ONLY WITH CONSENT. ANY RECORDING WOULD BE TEMPORARY AND DELETED AFTER ENTRY INTO THE PERMANENT MEDICAL RECORD.

I UNDERSTAND THAT MY/ MY WARD'S VISIT WILL BE TYPED INTO THE COMPUTER BY A VIRTUAL MEDICAL ASSISTANT.

Signature

PATIENT BILLING ESTIMATE DISCLAIMER

I ACKNOWLEDGE THAT THE AMOUNT I AM BEING ASKED TO PAY FOR THIS VISIT IS AN ESTIMATE. IT DOES NOT REPRESENT A PRICE GUARANTEE AND I UNDERSTAND THAT THE ACTUAL AMOUNT FOR THIS VISIT MAY BE HIGHER OR LOWER THAN THE ESTIMATE I AM ASKED TO PAY.

Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED TO:

- CONDUCT, PLAN AND DIRECT TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY AND INDIRECTLY.
- OBTAIN PAYMENT FROM THIRD PARTY PAYERS.
- CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I HAVE RECEIVED, READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. 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 ALSO UNDERSTAND THAT I CAN ACCESS THIS POLICY ON THE CLINIC'S WEBSITE AT ANY TIME.

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 HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT:

1. I AM EITHER THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE;
2. I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES: FOR MOORE COUNTY HOSPITAL DISTRICT; AND
3. I UNDERSTAND THAT I MAY CONTACT THE PERSON NAMED IN THE NOTICE IF I HAVE QUESTIONS ABOUT THE CONTENT OF THE NOTICE.

Signature

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PRESCRIPTION REFIL POLICY AFFIRMATION

IF YOU NEED A REFILL ON A PREVIOUSLY PRESCRIBED MEDICATION, **PLEASE CONTACT YOUR PHARMACIST ONE WEEK PRIOR TO NEEDING YOUR REFILL.** YOUR PHARMACIST WILL FAX US YOUR REQUEST ALONG WITH THE CURRENT DOSAGES AND MEDICATIONS FOR YOUR HEALTHCARE PROVIDER'S APPROVAL. **FAXED REQUESTS FROM THE PHARMACY RECEIVED AFTER 4 P.M WILL NOT BE DISTRIBUTED UNTILL THE FOLLOWING DAY THEREFORE STARTING THE 48 HOUR TURN AROUND.** FOR YOUR SAFETY, YOU MAY BE ASKED TO MAKE AN APPOINTMENT WITH YOUR HEALTH CARE PROVIDER BEFORE REFILLING YOUR MEDICATION. **PLEASE REMEMBER TO ALLOW 48 HOURS FOR YOUR REFILL REQUEST TO BE PROCESSED.**

MAIL-ORDER PHARMACIES:
IF YOU CHOOSE A MAIL-ORDER PRESCRIPTION SERVICE, YOUR HEALTH CARE PROVIDER WILL BE GLAD TO PRODUCE WRITTEN PRESCRIPTIONS FOR YOU TO MAIL. PLEASE CALL TO LET US KNOW WHEN PRESCRIPTIONS ARE NEEDED AND WE WILL PLACE THE WRITTEN PRESCRIPTIONS AT THE FRONT DESK FOR YOU TO PICK UP. REMEMBER TO ALLOW 2 WEEKS TO RECEIVE YOUR MEDICATIONS IN THE MAIL.

CONTROLLED SUBSTANCES:
ALL MEDICATIONS CLASSIFIED BY THE FDA AS A CONTROLLED SUBSTANCE WILL BE PRESCRIBED AT A MAXIMUM OF 30 DAYS. REFILLS WILL REQUIRE AN APPOINTMENT UNLESS THE PATIENT HAS SEEN PRESCRIBER FOR THAT PARTICULAR PROBLEM WITHIN THE LAST 30 DAYS.

***** I HAVE READ AND UNDERSTAND THE ABOVE POLICY*****

Signature
Date all Consents Signed

TO BE COMPLETED BY STAFF

PART 1. COMPLETE IF SIGNATURE REQUESTED BUT NOT OBTAINED:
STAFF MEMBER SOUGHT, BUT WAS UNABLE TO OBTAIN AN ACKNOWLEDGEMENT FROM THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE FOR THE FOLLOWING REASON:
O PATIENT/PERSONAL REPRESENTATIVE REFUSED TO SIGN FORM
O OTHER

PART 2. COMPLETE IF PATIENT/PERSONAL REPRESENTATIVE UNAVAILABLE TO SIGN FORM ON FIRST DAY OF SERVICE DELIVERY:
O FORM MAILED/SENT TO PATIENT/PERSONAL REPRESENTATIVE ON DATE:

PART 3. COMPLETE IF EITHER PART I OR PART 2 COMPLETED:

SIGNATURE OF STAFF MEMBER: **DATE:**

Revised 02.01.2024