Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

Welcome to Boerne Healthcare Group!

We would like to thank you for choosing us for your healthcare needs. We look forward to participating in your care and having you as one of our valued patients. We will provide you with high quality personalized care that is comprehensive focusing on prevention through education. Our vision involves a multi-interdisciplinary team approach to ensure your healthcare needs are met. We have enclosed some forms and information to prepare for your first visit. Please review, complete, and sign where applicable to ensure your first visit is efficient and effective.

Our clinic hours are Monday through Friday, 9:00 a.m. to 5:00 p.m. The clinic will be closed for lunch between 12:00 and 1:00 p.m. We offer an online patient portal for viewing medical records.

Our mission is to provide excellence in healthcare to all our patients. We recognize the high costs and the complexity of healthcare and will work toward reducing costs and stream-lining care. In that effort, Boerne Healthcare Group has developed essential policies and procedures that, with your assistance, will ensure a successful and long-lasting relationship.

Our promise to our patients is to include:

- A safe environment in which to discuss your concerns.
- High quality professional services that meet all our healthcare needs.
- Absolute dedication that places you and your needs first.
- An appropriate fee structure that exemplifies the quality of care delivered.

In return, we ask that our patients:

- Keep appointments and arrive at least 15 minutes ahead of time.
- Notify of cancelation at least one day in advance.
- Bring all your current medications with you to each appointment to promote safety in medication management.
- Bring your photo ID, health insurance information, and any outstanding fees owed with you to each visit.

Open communication is key to maintaining safe, quality, and effective healthcare between you and your provider. If you have any concerns or questions, please feel free to discuss with your provider or ask for the office manager.

Consult our website at www.boernehealthcaregroup.com as another option for communication.

Thank you, again, for joining us and being part of the team in taking care of you!

Sincerely,

Michelle Mourre
MSN, APRN-C, AGPCNP
Chief Executive Officer

17 Old San Antonio Road, Ste 202
Kronkosky Senior Center, 2nd floor.
Boerne, Texas, 78006
Phone: 830-331-9880 Fax: 210-519-3012

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Boerne Healthcare Group, PLLC, as your healthcare provider. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you received. We ask that you read this form to assist in understanding your financial responsibility. We want to reassure you that we are here to support you, and we encourage you to ask any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/ or by receiving medical services from Boerne Healthcare Group, PLLC ("BHG"), you agree:

1. Your understanding and agreement to the established policies and procedures of Boerne Healthcare Group, including but not limited to this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, are crucial. These policies, which you can request a copy of from the business office staff, may change from time to time by Boerne Healthcare Group, without notice. If there is any conflict between any policy or procedure of Boerne Healthcare Group and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this statement shall control. Your agreement to these policies and procedures is a sign of your commitment to your healthcare responsibilities, and we trust in your active participation in this process.
2. It's important to remember that you are ultimately responsible for all payment obligations arising from your treatment or care. This includes deductibles, copayments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier or our policies, which are not otherwise covered by supplemental insurance. Your awareness and accountability in this matter are crucial.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan determines that services you received at Boerne Healthcare Group are not medically necessary and/ or not covered by your insurance plan; (ii) your health plan coverage has lapsed or expired at the time you receive services at Boerne Healthcare Group; or (iii) you have chosen not to use your health plan coverage. If you are unfamiliar with your plan coverage, we recommend contacting your carrier or plan provider directly.
4. You will be required to follow all registration procedures, including updating or verifying personal information, presenting verification of current insurance, providing signatures, and paying any copays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file or cannot verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance, and if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your copay or other patient responsibility amount, your visit may be rescheduled by Boerne Healthcare Group.
5. By signing below, you authorize Boerne Healthcare Group to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to Boerne Healthcare Group, for application onto your bill for services, all of your rights and claims for the medical benefits to which you or your dependents are entitled under any federal or state health care plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payer arrangement that covers health care costs and for which payment may be available to

cover the cost of the services provided to you. You authorize Boerne Healthcare Group and associated providers and staff to release patient information acquired in the course of your examination and/or treatment including but not limited to any medical records, notes, test results, X-ray reports, MRI reports, or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process the claim to the necessary insurance companies, third-party payers, and/or other providers or healthcare entities as they require to participate in your care. It is important to notify us immediately of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Boerne Healthcare Group does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.

6. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges with the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit the same to Boerne Healthcare Group until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize Boerne Healthcare Group to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family or dependents account, or an account for which you are a financially responsible party, and any remaining balance would be returned to the payor.
7. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to submit a claim. You must notify us of any errors or objections to the billing statement within thirty (30) days, or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, you must contact Boerne Healthcare Group to address the problem or discuss a workable solution.
8. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of the receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will default and auto-referred to a collection agency. The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower. For small balances, between $4.01 to $25.00, we may stop sending billing statements any time after the initial statement. Still, you understand that the amount shall remain due and owing until paid in full.
9. We accept payment by check, cash, money order, debit, or credit card.
    a. **Payment by Check**. If payment is made by check and it is returned or declined for any reason, your account will be charged a surcharge of $20 or up to the applicable state maximum legal limits, whichever is lower, in addition to any costs assessed or charged by any depository institution. When you pay by check, you also authorize Boerne Healthcare Group, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state's maximum legal limits (plus any applicable sales tax). PLEASE NOTE: the above language authorizes an electronic debit to your account for the amount of the check plus the state-allowed recovery fee. Under the rules of the National Automated Clearinghouse Association, this authorization will remain in effect until Boerne Healthcare Group has received written notice of termination at such time and in such manner to afford us a reasonable opportunity to act on it. This does not, however, mean that Boerne Healthcare Group cannot collect a return check fee by other methods.
    b. **Payment by Credit Card/Debit Card.** You may pay with a credit or debit card, including Visa or MasterCard. Your payment with a credit card may be made in person, by mail, by calling the number on your billing statement, or through the Boerne Healthcare Group website. Once the submitted information is authorized, your credit card will be charged. If your charge is not accepted, you will be notified. You are responsible for all late charges or penalties resulting from the late receipt of any payment. Your information

is used solely to process your payment. While processing your credit card payment, only the last four digits of your credit card are viewable by Boerne Healthcare Group personnel. We do not otherwise store your sensitive credit card information.

10. **Managed Care (HMO, PPO, etc).** All managed care copayment amounts are due at the time of service. You acknowledge that it is your responsibility to be aware of what services are covered, and you agree to pay for any service deemed non-covered or not authorized by the plan.
11. **Medicare.** Boerne Healthcare Group is a participating provider with the Medicare program and accepts the Medicare allowable patient deductible and/ or 20% coinsurance as payment. Medicare or secondary carriers do not cover some procedures and supplies. Please ensure you understand which aspects of your treatment are covered before proceeding. You understand that you will be responsible for your annual deductible, the copayment, and any non-covered services specified by Medicare. By signing below, request that payment of authorized Medicare benefits be made on your behalf to Boerne Healthcare Group for any services furnished to you by Boerne Healthcare Group.
12. **Medicaid.** If you are a Medicaid patient, you must present a valid eligibility card at the time of registration and before the time of service. Your eligibility status will be verified monthly. Without verification of coverage, you will be responsible for the full/entire balance of your account. As a courtesy to you, your account will be billed to Medicaid when we receive all necessary information. You are responsible for non-covered portions and spend-down requirements associated with your individual coverage. If you are not eligible for Medicaid coverage and wish to be seen, you will be treated as a self-pay patient and must make payment at the time of service.
13. **Third party liability injuries.** If you receive treatment due to a third-party liability injury (for example, motor vehicle accidents, premises liability, or other liability claims against third parties), the balance for services rendered is considered due in full at the time of service. Because Boerne Healthcare Group does not protect charges incurred related to our rising out of third-party liability, we will not accept a delay in payment due to settlement disputes and/or litigation. We will not accept a letter of protection from an attorney as a guarantee of payment or assignment of third-party insurance payments. Boerne Healthcare Group cannot act as an administrator to resolve financial arrangements. We may agree to bill a third-party insurance company of an at-fault party involved in an accident as a courtesy to you. To bill your claim directly, you must provide us with all the necessary information to confirm coverage for these payments with the auto/third-party carrier. We will also collect information about your medical insurance in case the auto/third-party carrier denies your claim. Regardless of whether we submit your claim to 3rd party insurance, as the patient, you are ultimately responsible for payment.
14. **Ancillary services.** You may receive ancillary medical services while a patient of Boerne Healthcare Group, such as interpretation of tests and neuropsychological testing. By signing below, you understand that some providers may not provide services in your presence but are actively involved in the course of diagnosis and treatment. You authorize payment directly for these services under the policy(s) or plan(s) issued to you by your insurance carrier. You may incur additional charges because of these ancillary services. You agree to pay all charges due for such services after benefits paid on your behalf by any third party are credited to your account.
15. **Additional charges.** Patients may incur and are responsible for the payment of additional charges at the discretion of Boerne Healthcare Group, including but not limited to (i) charges for return checks, (ii) charges for missed appointments without 24 hours advance notice, (iii) charges for extensive phone consultations and/or after hours phone calls requiring treatment, or prescriptions; (iv) charges for copying and distribution of patient medical records; (v) charges for extensive forms preparation or completion; or (vi) any costs associated with collection of patient balances, all as allowed by law.
16. **Non-payment on account.** Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that Boerne Healthcare Group has the right to disclose to an outside collection agency or attorney all relevant personal account information necessary to collect

payment for services rendered. You are responsible for all costs of collection including, but not limited to (i) late fees and charges and interest due as a result of such delinquency; (ii) all court costs and fees (but only to the extent allowed by law); and (iii) a collection fee to be charged under separate agreement with a third party collections agency, either as a flat fee or computed as a percentage of the total balance due up to the maximum allowed by applicable law, and to be added to the outstanding balance due and owing at the time of the referral to the third party collection agency. You acknowledge that any such interest assessed on the account will be a late fee due to default or delinquency on your account and is not deemed interest as part of a credit transaction. If your account is referred to a collection agency, attorney, or court, or the past due status is reported to a credit reporting agency, it may have an adverse effect on your credit history and related portions of your account, including the fact that you received treatment at our offices, may become a matter of public record. Failure to comply with any of these policies may also result in a credit withdrawal of care. By signing below, you agree, on behalf of yourself, your legal representatives, and next of kin, that the jurisdiction, venue, and choice of law of any dispute or state court action related to the health care service for the billing provided by Boerne Healthcare Group shall, at the option of Boerne Healthcare Group, be subject to the exclusive jurisdiction of (i) the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered or (ii) where you reside.

17. **Authorization to contact.** You authorize Boerne Healthcare Group personnel to communicate by mail, answering machine messages, and/or e-mail according to the information provided in your patient registration information. Boerne Healthcare Group, or any agent or servicer of your patient account, may use any information you have provided, including contact information, e-mail addresses, cell phone numbers, and landline numbers, to contact you for purposes related to your account, including debt collection. You authorize Boerne Healthcare Group to use this information in any manner consistent with the information you have provided, including mail, telephone calls, emails, or text messages. You expressly consent to any such contact made by the most efficient technology available, including automatic dialing/ emailing or similar equipment or pre-recorded or other messages, even if you are charged for the contact.
18. **Financial responsibility party.** If this or a separate Boerne Healthcare Group financial responsibility statement is signed by another person on your account, then that co-signature remains in effect until canceled in writing. Cancellation in writing shall become effective the date after receipt and shall apply only to those services and charges therefore incurred. By signing as the financially responsible party, you hereby guarantee the full and prompt payment to Boerne Healthcare Group of all indebtedness of the patient to Boerne Healthcare Group, whether now existing or hereafter created (the “indebtedness”). You further agree to pay all expenses, legal or otherwise, incurred by Boerne Healthcare Group in collecting the indebtedness, in enforcing this guarantee, or in protecting its right under this guarantee or under any other document evidencing or securing any of the indebtedness. This guarantee shall be a continuing, absolute, and unconditional guarantee and shall remain in force until any indebtedness is fully paid. There shall be no obligation on the part of Boerne Healthcare Group at any time to first exhaust its remedies against the patient, any other party, or any other rights before enforcing the obligations of the Financial Responsibility Party.

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Boerne Healthcare Group PLLC, clinic PATIENT FINANCIAL RESPONSIBLIITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to Boerne Healthcare Group for the below patients care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any paid by a third party will be credited on the patient account;(v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I fail to make any of the payment for which I'm responsible and timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorney’s

fees (to the extent allowed by law); And (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report.

I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE, OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE EFFECT.

_____	_____	_____
Patient/Responsibility Party/Guardian	Date	Date of Birth

_____

Witness

_____	_____	_____
Patient/Responsibility Party/Guardian	Date	Date of Birth

_____

Witness

Waiver of Patient Authorizations

I do not wish to have information released and prefer to pay at the time of service and/ or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____	_____
Signature of Patient or Guardian	Date

Patient Registration Form

Patient Information

Patient Information				
	Last Name	**First Name**	**M.I.**	**Previous Name (if applicable)**
	Mailing Address:		**Apt. #**	
	City/State/Zip:			
	Home Phone:	**Cell Phone:**		**Work Phone:**
	Preferred Method of Contact for appointment reminders and messages: □ Voice □ Text			**If Voicemail, please select preferred #:** □ Home □ Cell □ Work
	Date of Birth:	**Gender:** □ Male □Female		
	Marital Status:		**Social Security #:**	
	Employer:		**Emergency Contact Name:**	

Additional Information/Emergency Contact		
	Emergency Contact Information:	
	Last Name:	**First Name:**
	Relationship to the Patient:	**Phone #:**
	Address:	
	City/State/Zip:	
	Additional Information: (PLEASE FILL OUT ALL SECTIONS BELOW)	
	Email Address:	**Do you want to receive Protected Health Information via Email?** □ Yes □ No
	Race: White □ African American □ Hispanic □ Other □	**Cultural Background:(e.g.: American, German, French etc)**
	Preferred Pharmacy Name, location, phone:	

Insurance Information	**Primary Insurance Information**	**Secondary/Supplemental Medical Insurance**
	Insurance Company Name:	**Insurance Company Name:**
	Policy Number:	**Policy Number:**
	Policyholder Name:	**Policyholder Name:**
	Policyholder Date of Birth:	**Policyholder Date of Birth:**
	Policyholder Social Security #:	**Policyholder Social Security #:**
	Patient Relationship to Policyholder:	**Patient Relationship to Policyholder:**

I have read and agree to Boerne Healthcare Group's (BHG) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to BHG all money to which I am entitled for medical expenses related to the services performed from time to time by BHG, but not to exceed my indebtedness to BHG. I authorize BHG to release any medical information to my insurance carrier or third-party payer to facilitate the processing of my insurance claims.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to BHG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Responsible Party _____ Printed name _____ Date _____

Boerne Healthcare Group

MEDICAL HISTORY

PATIENT NAME _____ **Birth Date:** _____

Reason for being seen today?

_____

Please provide a list of your other health care providers, if any:

_____

List any surgeries or hospitalizations you have had and when:

_____

_____

_____

SOCIAL HISTORY:

Are you on a special diet? □ Yes □ No

Do you use tobacco or vape? □ Current □ Former Smoker □ Never If so, packs/day: _____ for _____yrs.

Do you use alcohol? □ Current □ Former Drinker □ Never If so, drinks/day: _____

FAMILY MEDICAL HISTORY: (Please list any family member with chronic medical conditions)

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Additional Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my, or the patient's, health. It is my responsibility to inform BHG of any changes in medical status.

_____ _____ _____

Are you pregnant? Yes No N/A Are you taking oral contraceptives? Yes No Are you nursing? Yes No

Do you have or have you had any of the following:

○ Alzheimer's Disease	○ Epilepsy/Seizures	○ Kidney Problems	○ Skin Problems
○ Anemia	○ Headaches/Migraines	○ Liver Disease	○ Thyroid Problems
○ Arthritis	○ Heart Attack/Failure	○ Low Blood Pressure	○ Shingles
○ Asthma	○ Irregular Heart Rhythm	○ Osteoporosis	○ Infectious Disease
○ Blood Disorders	○ Pacemaker	○ Stroke	○ Spinal Disorders
○ Cancer	○ Heart Murmur	○ Irritable Bowel Disease	○ Bladder problems
○ Diabetes	○ High Blood Pressure	○ Crohns/Colitis	○ Vision/Hearing Issues
○ Emphysema/COPD	○ High Cholesterol	○ Prostate Problems	○ Disability

_____ _____ _____

Signature of patient or responsible party Printed Name Date

MEDICATION LIST

Please fill out this form.

Your name:

Your Medication Allergies	Reaction

Please list ALL your medications such as pills, inhalers, eye drops, patches, injections, creams, and so on. Also include any medications you buy over the counter such as herbal products and vitamins.

Your Pharmacy: **Your Family Doctor:**

Medication Name & Strength	**Dose** (How much do you take?)	**Directions** (How often do you take it?)

List reviewed/updated by (initial the actual change):

Print Name	Relationship	Date/Time

Additional Comments:

Boerne Healthcare Group
PRACTITIONERS IN EXCELLENCE

ROUTINE VACCINES & SCREENINGS

Screenings	Last Completed
Eye Exam (annually, starting at 65)	
Ear Exam/Hearing Test (annually, starting at age 65)	
Glaucoma Screen	
Cholesterol (every 5 years, high risk more often)	
Diabetes Screening (every 3 years at age 45, high risk more often)	
Fecal Occult Blood Stool tested annually	
Colorectal Screening (ages 45-80) FOB (annually) or Colonoscopy (every 10 years) or Sigmoidoscopy (every 5 years)	
Mammography (annually, starting at age 40)	
Pap Smear (Female age 21-65 every 3 years starting age 21, over 30 include HPV testing; over 30 interval can be extended to every 5 years by co-testing with combination PAP and HPV testing. Annual for women at high risk)	
Clinical Breast Exam (every 3 years ages 20-39, and annually, starting at age 40)	
Bone Density/Osteoporosis Risk Screening (women 65 or younger)	
Prostate Specific Antigen (PSA) Male starting at age 55)	
Depression Screen (annually)	
Abdominal Aortic Aneurysm Screen (former or current smoker male age 65-75)	
Smoking Cessation Counseling: up to 8 sessions/year	
Alcohol Use Counseling	
Exercise Counseling	
Depression Screen (annually)	
Cognitive Screening (annually, starting at age 65, per Medicare)	
Falls in the past year (number of falls/injury)	
COVID-19 Vaccine/Boosters	**Have not taken?** (check mark)
Influenza Vaccine	
Pneumonia Vaccine	
Tetanus Vaccine	
Shingles Vaccine	

Pfizer/Moderna/JJ	Month	Year

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

General Anxiety Disorder (GAD-7)

NAME

DATE

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
• Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
• Worrying too much about different things	☐ 0	☐ 1	☐ 2	☐ 3
• Trouble relaxing	☐ 0	☐ 1	☐ 2	☐ 3
• Being so restless that it's hard to sit still	☐ 0	☐ 1	☐ 2	☐ 3
• Becoming easily annoyed or Irritable	☐ 0	☐ 1	☐ 2	☐ 3
• Feeling afraid as if something awful might happen	☐ 0	☐ 1	☐ 2	☐ 3
Add the score for each column				
TOTAL SCORE *(add your column scores)*				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ 0	☐ 1	☐ 2	☐ 3

Scoring *Add the results for question number one through seven to get a total score.*

If you score 10 or above you might want to consider one or more of the following:

1. Discuss your symptoms with your doctor,
2. Contact a local mental health care provider or
3. Contact my office for further assessment and possible treatment.

Although these questions serve as a useful guide, only an appropriate licensed health professional can make the diagnosis of Generalized Anxiety Disorder.

A score of 10 or higher means significant anxiety is present. Score over 15 are severe.

GUIDE FOR INTERPRETING GAD-7 SCORES

Scale	Severity
0-9	None to mild
10-14	Moderate
15-21	Severe

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al.

Boerne Healthcare Group
PRACTITIONERS IN EXCELLENCE

ANNUAL PHYSICAL VISITS vs OFFICE VISITS

Annual Physical, Preventive, or Wellness Visit	Office Visit, Sick Visit, or Medication Management
Focused on prevention, education, immunization, and annual screenings. **Physical Exams may include:** 1. **Well Women's Visit – Pap smears, breast exams** 2. **Male Exam – Prostate & Testicular Screenings** 3. **Skin inspection** 4. **Fall Risk Assessment** 5. **Cognitive Assessment** 6. **ADLs and IADLs Assessment** 7. **Immunizations** 8. **Follow up lab testing as appropriate** 9. **Referrals for:** a. **Mammogram** b. **Colonoscopy** c. **Eye Exams** d. **Hearing Tests** e. **Bone Scan** **Wellness visits are usually copay exempt. If a new or chronic condition(s) are addressed, an office visit will also be performed and billed.**	**The appointment visit will include discussion and evaluation of a new or existing mental health condition or medical condition:** **Office Visit/Follow Up appointment will be to:** 1. **Evaluate and treat symptoms and concerns.** 2. **Address Chronic problems.** 3. **Adjust medications and process refills.** 4. **Laboratory testing results to be ordered or reviewed.** 5. **Request and/or process referrals.** **Copays, deductibles, and co-insurance may apply.**

MEDICARE VISITS EXPLAINED

Medicare Coverage of Physical Exams—Know the Differences

Initial Preventive Physical Examination (IPPE)

Review of medical and social health history, and preventive services education

- ✔ Covered only once, within 12 months of Part B enrollment
- ✔ Patient pays nothing (if provider accepts assignment)

Annual Wellness Visit (AWV)

Visit to develop or update a personalized prevention plan, and perform a health risk assessment

- ✔ Covered once every 12 months
- ✔ Patient pays nothing (if provider accepts assignment)

Routine Physical Examination (See Section 90)

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury

- ⊘ Not covered by Medicare; prohibited by statute
- ⊘ Patient pays 100% out-of-pocket

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

Introduction

It is the physician's responsibility to ensure that the physician-patient relationship is confidential. The Health Portability and Accountability act (HIPAA) allows physicians to use their professional judgment on disclosing certain personal health information to family, friends, etc. Without an authorization. This form is an aid to the physicians in making a determination on disclosing such information. Boerne Healthcare Group realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medial needs. Your provider wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below.

Please note the follow points:

- If you designate no one, Boerne Healthcare Group will not release information to any family member, friend or legal representative.
- This Release of Information expires 1 year from the date it is signed.
- This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to the provider at Boerne Healthcare Group, or other staff member, should it be necessary, on my behalf. I hereby give permission to Boerne Healthcare Group through its providers and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Boerne Healthcare Group its providers, and staff, from any claim of confidentiality in connections with the release of this information.

Name	Relationship	Phone #

Patient's Name: _____ Patient's Signature: _____

Date: _____ Witness: _____

I decline to designate another person to speak with my physician or clinical staff.

Patient's Signature: _____ Date: _____ Witness: _____

Boerne Healthcare Group

17 Old San Antonio Road, Suite 202
Boerne, Tx, 78006
Phone: 830-331-9880
Fax: 210-519-3012
Email: contact@boernehealthcaregroup.com

Cancellation, No show and Late arrival policy

In an effort to maximize the time your physician spends with you and minimize your wait time, we have made changes to our No-Show, Cancellation, and Late Arrival Policies as follows.

Noshow policy

Effective June 1, 2024, we will implement a "cancellation, no-show" policy, which will affect all patients who do not keep their scheduled appointment or who cancel an appointment with less than a 24- hour notice.

- First occurrence – Patient will be charged a fee of $25.00.
- Second occurrence – Patient will be charged $55.00 no show fee
- Third and subsequent occurrences – May result in dismissal from practice and additional $75 no show fee.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

Late arrival policy

Patients arriving more than 20 minutes late for a scheduled follow up visit or new patient visit appointment will be rescheduled for another day.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to management.

Please sign below that you have read, understand, and agree to this policy.

Patient Name _____

Date of Birth _____

Signature of Patient or Patient Representative

_____ **Date** _____

PLEASE COMPLETE THIS SECTION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(The Notice of Privacy Practices is available for review on the website at www.boernehealthcaregroup.com)

Practice Name: BOERNE HEALTHCARE GROUP

I acknowledge that I have reviewed a copy of the Practice's Notice of Privacy Practices.

_____ ___/___/____

Print Name Date of Birth

_____ ___/___/____

Patient (or Patient Representative*) Signature Today's Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

	Individual refused to sign
	Communication barriers prohibited obtaining the acknowledgement
	An emergency situation prevented us from obtaining acknowledgement
	Other (Please specify)

Boerne Healthcare Group

17 Old San Antonio Road, Suite 202
Boerne, Tx, 78006
Phone: 830-331-9880
Fax: 210-519-3012
Email: contact@boernehealthcaregroup.com

Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

THE NO SURPRISES ACT

STANDARD NOTICE AND CONSENT DOCUMENTS

(OMB Control Number: 0938-1401)

Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care. If you are uninsured, this document is to let you know what your estimated costs will be fore care.

IMPORTANT: You aren't required to sign this form and should not sign it if you did not have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you are getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

You **should not** sign this form if you **did not** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

Boerne Healthcare Group
PRACTITIONERS IN EXCELLENCE

Estimate of what you could pay: from $20.00 to $250.00 depending based on out-of-network or self-pay

Patient Name: _____

Out-of-network provider(s) or facility name: Boerne Healthcare Group PLLC

Total cost estimate of what you may be asked to pay:

- ▶ Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.
- ▶ Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ Questions about this notice and estimate? Call Boerne Healthcare Group at 830-331-9880 or email at contact@boernehealthcaregroup.com.
- ▶ Questions about your rights? Contact www.cms.gov/nosurprises or call 1-800-985-3059.

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.

More information about your rights and protections

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under federal law.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care, or I am agreeing to the cost estimate for self-pay if I am uninsured.

With my signature, I am saying that I agree to receive items or services from:

Michelle A. Mourre, CNP

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice. • I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

IMPORTANT: You do NOT have to sign this form. But if you do NOT sign, this provider might not treat you. You can choose to get care from a provider or in your health plan's network.

_____	or	_____
Patient's signature		Guardian/authorized representative's signature
_____		_____
Print name of patient		Print name of guardian/authorized representative
_____		_____
Date and time of signature		Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

Boerne Healthcare Group

PRACTITIONERS IN EXCELLENCE

FEDERAL TAX ID: 45-4406550
GROUP NPI: 1720791056

More details about your estimate.

Patient name: _____

Out-of-network provider: Boerne Healthcare Group PLLC

The amounts highlighted below are only estimates; they are not offers or contracts for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan will cover, which means that the final cost of services may be different from this estimate. Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

Initial Visit New OON or Uninsured Patients			50% discount
New Patient Visit (Age 18 - 29)	$220.00	-$110.00	$110.00
New Patient Visit (Age 30 - 44)	$330.00	-$165.00	$165.00
New Patient Visit (Age 45 - 59)	$430.00	-$215.00	$215.00
New Patient Visit (Age 60 – 79)	$520.00	-$260.00	$260.00
New Patient Visit (Age 80 – 100+)	$600.00	-$300.00	$300.00
Est Patient Follow Up Visit OON or Uninsured Patients			
Est Patient Follow-Up Visit (1 Problem)	$110.00	$55.00	$55.00
Est Patient Follow-Up Visit (2 Problems)	$180.00	$90.00	$90.00
Est Patient Follow-Up Visit (3 problems)	$250.00	$125.00	$125.00
Est Patient Follow-Up Visit (4+ problems)	$350.00	$175.00	$175.00
Other Common Testing & Services (Inquiries are required for other services not listed)			
Urinalysis by Urine Analyzer			$30.00
12L ECG			$95.00
Strep Test			$10.00
Influenza Test			$22.00
Hgb A1c			$25.00
Glucose Check			$5.00

Total Estimate: This good faith estimate explains our rates for each service provided by Boerne Healthcare Group. Telehealth or in-person charges are identical. Not all services are listed. The patient is responsible for inquiring about any additional charges included in the proposed care or treatment.

Authorization for Release of Personal Health Information (PHI)

Must BE Completed for All Authorizations: PLEASE COMPLETE HIGHLIGHTED AREAS ONLY

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____ SSN: _____

Person/organization providing the information:	**Person/organization receiving the information:**
	Boerne Healthcare Group
	17 Old San Antonio Road, Suite 202
	Boerne, Texas, 78006
	Fax: 833-972-1677

The purpose for this authorized release of information is _____MEDICAL REVIEW_____ and is at the request of the individual.

I authorize the health care provider to release the information specified below to the organization, agency, or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If there are not marked they cannot be released.

☐ Drug Abuse	☐ Substance Abuse	☐ Psychological or Psychiatric conditions	☐ AIDS/HIV

Please release the following records:

	History & Physical		Recent lab results		Recent Imaging Results		Progress Notes
	All records generated in your office						
	Records that apply to these specific dates of treatment						
	Records that apply to this specific problem or intervention						

Are you leaving our practice? Yes No
If yes, please explain: _____

Must be Completed for All Authorizations:

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations ad that the information may be redisclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____

Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby revoke this authorization, effective _____.

_____ _____ _____

Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**