Ranger Clinic

PATIENT DEMOGRAPHICS – please **COMPLETE ALL** information

Patient:

Last Name: _____ First Name: _____ M(Initial) _____

Mailing Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Phone: Cell _____ Home: _____ Work: _____

Date of Birth: _____ SSN: _____ DL/ID#: _____ State: _____

Marital Status: ___ Married ___ Divorced ___ Widowed ___ Single ___Separated ___ Domestic Partner

Gender: ___Male ___ Female Race: _____ Ethnicity: _____

Email Address (necessary for access to patient portal): _____

Emergency Contact: _____ Relationship: _____

Home/Cell Phone: _____ Work Phone: _____

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

Pharmacy Preferred: _____ Address _____

Insurance:

Company: _____ ID#: _____ Group #: _____

Primary Insured's Last Name: _____ First Name: _____

Date of Birth: _____ Relationship to Primary Insured: _____

Phone: _____

I authorize payments of insurance benefits to be made directly to Michelle Hancox or other healthcare professionals at Ranger Clinic for all medical services provided to me. I understand that I am financially responsible for charges not covered by my insurance. I also understand that I am expected to pay all deductibles, copayments, or payments in full, if I do not have insurance coverage at the time of service. Unpaid balances past 90 days will be sent to collections, affecting my credit. I also certify that I understand and agree to the above statements, releases, and assignment of benefits.

_____ _____

PRINT Patient name Signature of Patient/Legally Authorized Representative

_____

Date

Ranger Clinic

HIPAA PRIVACY NOTICE

I authorize Ranger Clinic to release my medical information pertaining to my diagnosis and/or treatment, laboratory results, test results, medical history, or any other such related information to my insurance company or its designated representatives, any person(s) or entities financially responsible for my care or treatment, representatives of local, state, federal agencies in accordance with law, employees or representatives of Ranger Clinic for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Ranger Clinic or Ranger Clinic employees.

I understand Ranger Clinic might notify me by phone, text, or email for the following reasons:

- Appointment reminders either by personal message, recorded message, text, and/or email
- Message(s) to call the office for test results. **Actual results will not be left by voicemail message.**
- Text or email messages regarding general test results without specifics for what test results were for
- **IF I DON'T LIST ANYONE BELOW, NO INFORMATION WILL BE DISCLOSED TO ANYONE BUT MYSELF**

I authorize Ranger Clinic to disclose my **MEDICAL INFORMATION** pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any other such related information to those listed below:

Name (print)	Relationship (print)	DOB (verification purposes)
Name (print)	Relationship (print)	DOB (verification purposes)

I authorize Ranger Clinic to disclose my **FINANCIAL INFORMATION** such as insurance information and billing records to those listed below:

Name (print)	Relationship (print)	DOB (verification purposes)
Name (print)	Relationship (print)	DOB (verification purposes)

This authorization expires six (6) years from the signature date, unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further my health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization signed by me prior to the disclosure of my medical information. We take HIPAA laws very seriously and are committed to protecting our patient's health and financial information secure, which is why verbal authorization will not suffice for us to release information of any kind.

Patient Name (print)	Patient Signature/Legally Authorized Representative
Date	Ranger Clinic Witness

RANGER CLINIC
6009 FM 307, Midland Texas, 79706
432-247-1441
rangerclinic@att.net

Patients Name_____ **DOB:**_____

Responsible Party Name:_____ **Relationship:**_____

- "I acknowledge receiving a copy of the notice of privacy practices."

Thank you for choosing RANGER CLINIC as your provider of services. We appreciate the opportunity and privilege of participating in your care . With respect to payment of service, please review the following policies.

- Fees are charged for the professional services rendered. You, as the responsible party, accept complete financial responsibility for payment of all services provided.

- You are excepted to pay all deductibles, co-pays, co- insurance amount and non-covered services at the time of service,If you have a high deductible plan (500.00 or more) you are required to pay for services at the time of services at the time of service until the deductible is met in full._____(Initial)

- You are financially responsible for payment in ***FULL*** for any services that are denied as a non-covered service, not medically necessary, or if you failed to notify us of change in insurance coverage, or if you did not obtain a referral or authorization as required by your insurance company._____(Initial)

- You are responsible for notifying RANGER CLINIC immediately of any changes in your insurance policy and for obtaining insurance related referrals and or authorizations._____(Initial)

- If payment on a claim we submit to Medicare, private insurance companies, or the third party payer within 90 days, you are responsible for payment of the balance in full at that time. If your insurance company makes payment after 90 days, you will be issued a refund within 30 days of payment equal the the amount paid by the insurance company. _____ (Initial)

- If RANGER CLINIC is not a participating provider (OUT OF NETWORK) with your insurance company,you are responsible for the payment in full at the time of service. We will submit your claim to your insurance company on your behalf. If you insurance company makes a payment of the claim, you will be issued a refund in that amount.(Initial)_____

- I Understand the RANGER CLINIC can NOT guarantee payment from participating insurance providers for service. Therefore, if my insurance carrier denies payment, I agree to be FULLY responsible for payment (initial)_____

_____ _____

Responsible party signature Date:

Ranger Clinic
6009 FM 307
Midland Texas 79706
(432)247-1441

NO CALL / NO SHOW

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time.

If an appointment is not canceled or patient fails to show up for appointment, Ranger Clinic reserves the right to charge patient a $50 fee per occurrence. As this fee is not billed to any insurance company, patient accepts full responsibility to pay this fee.

If you have any questions about this form, please talk to us before signing.

Patient's Name: _____

Patient's / Guardian's Signature: _____

Date: _____