Complete Healthcare Services, PA
315 W Houston St
Jasper, Texas 75951
409.384.3430

PATIENT REGISTRATION

Patient Information

Name:	SSN:
Address:	Date of Birth:
	Sex:
	Language
Home Phone:	Race:
Cell Phone:	Ethnicity:
Work Phone:	Marital Status
Email Address:	Preferred method of contact: Printed Electronic Phone/Text

Insurance Information

Primary Insurance	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Group Number:
Secondary Insurance	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Group Number:

Emergency Contact

Emergency Contact Name:	Phone Number:
Relationship:	DOB:

Pharmacy Information

Pharmacy Name:	Phone Number:
Address:	

RX History Consent: I hereby authorize **Complete Healthcare Services, PA** to obtain my previous prescription/medication history through external sources: _____(Initial)

Health Information Exchange: I hereby authorize **Complete Healthcare Services, PA** to send and receive my health information from other providers within our CommonWell and CareQuality networks, to include but not limited to hospitals and other specialist, upon request. _____**(Initial)**

The above information is complete and correct. I hereby authorize the release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to **Complete Healthcare Services, PA**. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at the time of services and/or deductibles, additional fees for form processing, returned checks, copying of medical records, and missed appointments that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

_____ _____
Patient or Guarantor Signature Date

_____ _____
Witness Signature Date

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CONSENT FOR TREATMENT

_____ **Initial**

I understand various screening/diagnostic procedures may be necessary to diagnose my condition and that I will be given various treatment options following diagnosis. I hereby give Complete Healthcare Services providers and ancillary staff the authority to perform the screening/diagnostic studies deemed necessary and/or the treatment options of my choice.

I understand that Complete Healthcare Services employs the services of mid-level practitioners (Physician Assistants and/or Nurse Practitioners) to assist in patient care. I understand that under certain circumstances the physician will not be available and, as such, I will be offered the services of the PA and/or NP. By circling the answer and my signature below I am indicating my willingness or unwillingness to be treated by a mid-level provider in the event the physician is unavailable. I understand that physician availability is determined by appointment schedule, surgery schedules, emergencies, and/or on-call status. If I present to the clinic without an appointment, I will be offered the services of the PA and/or NP or asked to make an appointment with the physician at another time if no appointment time is available.

*** I am willing to be seen by a mid-level provider in the event a physician is unavailable. Yes No**

ELECTRONIC PRESCRIBING CONSENT

_____ **Initial**

Complete Healthcare Services provides electronic prescriptions (E-Prescribing) to pharmacies through SureScripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need or a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe. By signing below, you are indicating you understand the above listed refill policies and authorize Complete Healthcare Services to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medical dispense history as long as you are a patient at this office or until you withdraw that consent.

OUTSIDE SERVICES BILLING

_____ **Initial**

I understand that certain laboratory studies will have to be sent out to a reference lab, i.e. Quest or LabCorp. This lab will send a separate bill for those studies. I understand that Complete Healthcare Services charges a technical fee for equipment, technicians and other operating expenses. I understand I will be receiving a separate bill from the reference lab for any lab work sent to them.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

_____ **Initial**

I acknowledge I have reviewed this office's Notice of Privacy Practices available on the office website, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions, if I do not understand. I understand I am entitled to a copy of this document upon request.

RELEASE OF INFORMATION

I give Complete Healthcare Services permission to release and/or receive protected health information as requested by other healthcare providers in the continuity of my care.

_____	_____	___/___/___
Name	**Signature**	**Date**

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Complete Healthcare Services New Patient Screening

Name: _____DOB: _____SEX: M F SSN:_____

Address: Phone Number:

City State Zip:

Please List **ALL Medications** Patient Is Currently Taking (Including Dosage & How Taking):
Example*: Lisinopril 5 mg 1 every day*.) Please use back of page if needed.

Please List **ALL** Pain Medications The Patient Has Taken In The Last 5 Years: Please use back of page if needed

Please List Any Surgeries and Dates of Surgeries: Please use back of page if needed

Are you currently under the care of any specialists?
Please List All Specialists That You Have Seen: Please use back of page if needed.

What Type of Visit Does Patient Need: Establish Care Medication Refill Other/Explain

I understand and acknowledge that completing this form does not establish a doctor-patient relationship. This does not guarantee acceptance as a patient in this clinic. I hereby give consent for Complete Healthcare Services to perform a medication history check with the Texas Board of Pharmacy.

Signature_____ Date_____

Approved By:_____Date:_____

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Current Medications List:

Pain Medications List:

Surgeries:

Specialists:

Patient/Guardian Signature	Printed Name	Date
_____	_____	___/____/____
Witness Signature	Printed Name	Date

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PRESCRIPTION REFILL POLICIES

Prescription refills

- If you are prescribed medications, you will be provided with an initial prescription and refills to last until the suggested follow-up visit. **It is your responsibility** to schedule your follow-up appointment before the prescription runs out to insure a continued supply of medication.
- Medication refill requests will not be authorized if you fail to keep your follow-up appointments. To give good clinical care patients must be seen on a regular basis.
- Only minor changes in your medication regimen can be made between appointments. If a major change in your medication regimen is needed you will need to be seen by your provider before these changes can be made.
- **We do not accept faxed refill requests from your pharmacist.**
- It may take up to 48 hours for reviewing your medical history and deciding if the requested refill is appropriate.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescription refills will not be provided on the weekends.
- All medications are to be taken as prescribed. If patient takes medication in excess of what is prescribed and runs out of medication early (prior to refill date), the refill will not be authorized until refill date.
- In general, if a patient is already being treated by a pain management physician, all pain medications will need to be managed by the patient's existing pain management specialist.
- We require regular blood work for all patients on prescription medication, which is necessary for monitoring the safety and effectiveness of the medication. The interval will vary based on the medication prescribed. Patients who do not schedule for their regular intervals of blood work will not have their prescriptions refilled.
- Complete Healthcare Services provides electronic prescriptions (E-Prescribing) to pharmacies through SureScripts. E-Prescribing involves the ability for the practice to send prescriptions electronically to pharmacies, eliminating the need or a more time-consuming, and sometimes more costly, approach to prescribing through paper, phone and fax. E-Prescriptions are fast, convenient, legible, secure, cost-effective and safe.

By signing below, you are indicating you understand the above listed refill policies and authorize Complete Healthcare Services to electronically transmit prescriptions to the pharmacy of your choice, review pharmacy benefit information and medication dispensing history as long as you are a patient at this office or until you withdraw that consent.

Patient Name: _____ DOB: ____/____/____

Patient Representative: _____ Relationship:_____

Signature of Patient or Representative: _____ Date: ____/____/____