PILLAR FAMILY HEALTH CARE
KERRI PILLAR, PLLC ~ FAMILY NURSE PRACTITIONER
303 E. Airline Rd., Suite 1, Victoria, TX 77901 (361) 649-3451 (361) 214-7252 Fax

PATIENT REGISTRATION FORM

Patient Information

Patient Information:

Last Name:	First Name: MI:	Previous Name (if applicable)
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Preferred contact phone number ☐ Home ☐ Cell ☐ Work	Email:	
Family Physician or Pediatrician:		Sex: ☐ Male ☐ Female ☐ Transgender
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____		Employer Name:
Social Security Number:	Date of Birth:	Emergency Contact Name:
Emergency Contact Phone Number:	Relationship to Patient:	
Preferred Pharmacy Name and Location:		

Additional Information and Responsible Party

Responsible Party: If the patient is a minor (under the age of 18) the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:	
Address of Responsible Person:		
City/State/Zip:		Phone:
Social Security Number:	Date of Birth:	Relationship to Patient:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance	Other Method of Payment ~ Please check one
Insurance Company Name:	Insurance Company Name:	☐ Self Pay
Policy Holder Name:	Policy Holder Name:	☐ Medicare
Policy Holder Number:	Policy Holder Number:	☐ Medicaid
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:	☐ Tricare
Policy Holder's Social Security Number:	Policy Holder's Social Security Number:	
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:	

I certify that I have read and agree to Kerri Pillar, PLLC's Patient Financial and Payment policy.

Patient Signature _____ Date: _____

	Patient Financial & Payment Policy
	• **This financial payment policy is an agreement between Kerri Pillar, PLLC and you, the patient or responsible party.** • **By signing the Patient Registration Form you are acknowledging that you understand and agree to our financial payment policy.** **<u>Patient Responsibility</u>** • **You must provide us with a current insurance card and billing information. Your insurance policy is a contract between you and the insurance company. It is your responsibility to know your insurance benefits. We will bill all insurance plans, but we do not guarantee coverage. We will bill you for any remaining portion due after insurance processes your claim.** • **Co-pays are due at time of service.** • **NSF Fees: a $20.00 returned check fee will be charged for checks returned due to insufficient funds.** • **I am eligible for the insurance indicated on the Patient Registration Form and I understand that payment is my responsibility regardless of insurance coverage** • **I understand that I am finically responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, copay, or any service(s) deemed a "non-covererd" benefit by my insurance company.** • **I understand that failure to pay outstanding balance within 90 days of receiving my first statement will result in submission of my account for collection. In addition, failure to pay delinquent account balances may result in termination of care from Kerri Pillar, PLLC.** • **I authorize Kerri Pillar, PLLC to submit insurance claims on my behalf.** • **I hereby assign to Kerri Pillar, PLLC all money to which I am entitled for medical expenses related to the services performed by Kerri Pillar, PLLC, but not to exceed my indebtedness to Kerri Pillar, PLLC.** • **I authorize the release of any medical information necessary to process the claim.** • **I authorize payment of medical benefits to be paid directly to Kerri Pillar, PLLC for services described on the claim.** • **I request that payment of authorized Medicare benefits be made to Kerri Pillar, PLLC. I authorize any holder of medical information about me to release to Kerri Pillar, PLLC and her agents any information needed to determine these benefits or the benefits payable for related services.**

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PATIENT AUTHORIZATION AND CONSENT FORM

Patient Authorizations and Consents
Insurance Information

Treatment Provided by a Nurse Practitioner

I hereby give my consent to be treated by a Nurse Practitioner, who I understand is not a physician. This consent is granted until I withdraw this consent in writing.

Patient Signature _____ Date: _____

Medical Information ~ Consent for Release

I authorize Kerri Pillar, PLLC to release any medical or billing information necessary, for treatment, payment or healthcare operations to the following persons :

Name:	Relationship:	Phone number:
Name:	Relationship:	Phone number:
Name:	Relationship:	Phone number:
Name:	Relationship:	Phone number:

Patient Signature _____ Date: _____

Consent to Photograph

I hereby consent to the use of photographs by Kerri Pillar, PLLC for patient identification purposes. Pictures may also be obtained of any skin disorder or wounds for the purpose of medical documentation and evaluation of progress of such disorders or wounds. I give this consent voluntarily.

Patient Signature _____ Date: _____

Refusal Signature _____ Date: _____

Witness Signature _____ Date: _____

Telehealth Informed Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals and remote patient monitoring are all considered telehealth services. I have read and understand that attached Telehealth Policy.

Patient Signature _____ Date: _____

Telehealth Informed Consent

- **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services.**
- **I understand that telehealth involves the communication of my medical and mental health information in an electronic or technology assisted format.**
- **I understand that I may opt out of a telehealth visit at any time. This will not affect my ability to receive care at this office.**
- **I understand that telehealth services can only be provided to patients, including myself, who are residents or physically located in the State of Texas at the time of service.**
- **I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier (s), Medicare, Medicaid and it is my responsibility to check with my insurance plan to determine coverage.**
- **I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to :**
    - **Electronic communication being forwarded, intercepted or even changed without my knowledge despite taking reasonable measures**
    - **Electronic communications being accessed by employers, friends or others which are not secure and should be avoided. It is important for me to use a secure network.**
    - **Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.**
- **I agree that information exchanged during my telehealth visit will be maintained by the doctors, healthcare providers and healthcare facilities involved in my care.**
- **I understand that medical information, including medical records are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).**
- **I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.**
- **The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.**
- **I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.**
- **I understand that I have a responsibility to verify that identity and credentials of healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.**
- **I understand that electronic communication cannot be used for emergencies or time-sensitive matters.**
- **I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations – including further diagnostic testing, such as lab testing, a biopsy or an in-office visit.**
- **I understand that electronic communication may be used to communicate highly sensitive medical information such as treatment for or information related to HIV/AIDS, sexually transmitted diseases or addiction treatment.**
- **I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.**
- **By beginning the visit, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.**
- **I understand that there is never a warranty or guarantee to a particular result or outcome related to a condition or diagnosis when medical care is provided.**
- **To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.**
- **I certify that I have read and understand this agreement and that I have had the opportunity to have questions answered to my satisfaction.**

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PATIENT INFORMATION FORM

Name: _____ **Gender:** _____ **DOB:** _____ **Date:** _____

Allergies: _____
_____

PERSONAL MEDICAL HISTORY: (Please circle all that apply) **None** ☐

ADHD	COPD/Emphysema	Hepatitis	Osteopenia/Osteoporosis
Alcoholism	Crohn's Disease	Hiatal Hernia	Parkinson's Disease
Allergies/Seasonal	Dementia	High Blood Pressure	Peripheral Vascular Disease
Anemia	Depression	High Cholesterol	Peptic Ulcer
Anxiety	Diabetes 1 or 2	HIV	Psoriasis
Arrhythmia	Diverticulitis	Irritable Bowel Syndrome	Pulmonary Embolism (PE)
Arthritis	DVT (Blood Clot)	Kidney Disease	Rheumatoid Arthritis
Asthma	GERD (Acid Reflux)	Kidney Stones	Seizure Disorder
Bipolar	Glaucoma	Lupus	Sleep Apnea
Bladder problems	Headaches	Liver Disease	Stroke
Bleeding problems	Heart Disease	Macular Degeneration	Thyroid Disease
Cancer: _____	Heart Attack (MI)	Neuropathy	Ulcerative Colitis

Other Medical Problems Not Listed Above: _____
_____
_____
_____

Surgical History: Please list all prior surgeries and approximate dates performed.
_____
_____
_____
_____
_____
_____

WHEN WAS YOUR LAST:

Exam: _____
HIV Test: _____
TB Test: _____
Hepatitis Shot: _____

Colonoscopy: _____ Normal/abnormal
Bone density: _____ Normal/abnormal
Tetanus Shot: _____
Flu Shot: _____

Chest Xray: _____
EKG: _____
Pneumonia Shot: _____

Men:
Prostate Blood Test: _____
Exam: _____

Women:
Breast Exam: _____ Normal/abnormal
Mammogram: _____Normal/abnormal
Pap smear: _____ Normal/abnormal
Menstrual period: _____Normal/abnormal

Number of Pregnancies: _____
Number of live births: _____

SOCIAL/ CULTURAL HISTORY:

Education level: ☐ High School ☐ Vocational ☐ College ☐ Graduate/Professional

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Current living situation: (Check all that apply)

☐ Single Family Household ☐ Multi-generational Household ☐ Skilled Nursing Facility ☐ Other _____

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never **Type:** _____ **Amount/day:** ____ **Number of Years:**___

Alcohol: ☐ Current ☐ Past ☐ Never **Drinks per week:** _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never **Type:** _____

Are you sexually active: ☐ Yes ☐ No

Are there any personal problems or concerns at home, work or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments: (Please feel free to comment on any answers above)

_____

_____

FAMILY HISTORY:

MOTHER: **Living age:**_____ **Deceased: Age** _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disease
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS: _____

FATHER: **Living age:**_____ **Deceased: Age** _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disease
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MATERNAL GRANDFATHER: **Living age:**_____ **Deceased: Age** _____

Alcoholism	**Bipolar Disorder**	**Depression**	**High Cholesterol**	**Osteoporosis**
Anemia	**Cancer:** _____	**Diabetes 1 or 2**	**High Blood Pressure**	**Stroke**
Asthma	**COPD/Emphysema**	**DVT (Blood Clot)**	**Kidney Disease**	**Thyroid Disease**
Arthritis	**Dementia**	**Heart Disease**	**Migraines**	

Other: _____

MATERNAL GRANDMOTHER: **Living age:**_____ **Deceased: Age** _____

Alcoholism	**Bipolar Disorder**	**Depression**	**High Cholesterol**	**Osteoporosis**
Anemia	**Cancer:** _____	**Diabetes 1 or 2**	**High Blood Pressure**	**Stroke**
Asthma	**COPD/Emphysema**	**DVT (Blood Clot)**	**Kidney Disease**	**Thyroid Disease**
Arthritis	**Dementia**	**Heart Disease**	**Migraines**	

Other: _____

PATERNAL GRANDFATHER: Living age:_____ **Deceased: Age** _____

Alcoholism	**Bipolar Disorder**	**Depression**	**High Cholesterol**	**Osteoporosis**
Anemia	**Cancer:** _____	**Diabetes 1 or 2**	**High Blood Pressure**	**Stroke**
Asthma	**COPD/Emphysema**	**DVT (Blood Clot)**	**Kidney Disease**	**Thyroid Disease**
Arthritis	**Dementia**	**Heart Disease**	**Migraines**	

Other: _____

PATERNAL GRANDMOTHER: **Living age:**_____ **Deceased: Age** _____

Alcoholism	**Bipolar Disorder**	**Depression**	**High Cholesterol**	**Osteoporosis**
Anemia	**Cancer:** _____	**Diabetes 1 or 2**	**High Blood Pressure**	**Stroke**
Asthma	**COPD/Emphysema**	**DVT (Blood Clot)**	**Kidney Disease**	**Thyroid Disease**
Arthritis	**Dementia**	**Heart Disease**	**Migraines**	

Other: _____

List other Medical Providers you see on a regular basis and date of last appointment: (ie Cardiologist, Mental Health, Kidney Doctor, Dentist, etc.) _____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

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Name: _____ **DOB:** _____ **Date:** _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins:

No Routine Medications ☐

1. **Name:**_____ **Dose:** _____ **How taken:** _____
2. **Name:**_____ **Dose:** _____ **How taken:** _____
3. **Name:**_____ **Dose:** _____ **How taken:** _____
4. **Name:**_____ **Dose:** _____ **How taken:** _____
5. **Name:**_____ **Dose:** _____ **How taken:** _____
6. **Name:**_____ **Dose:** _____ **How taken:** _____
7. **Name:**_____ **Dose:** _____ **How taken:** _____
8. **Name:**_____ **Dose:** _____ **How taken:** _____
9. **Name:**_____ **Dose:** _____ **How taken:** _____
10. **Name:**_____ **Dose:** _____ **How taken:** _____

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected heath information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the providers' practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to health care students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research Criminal Activity and National Security, Worker's Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request may state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclosure of your protected health information your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 1, 2018.**

We are required by law to maintain the privacy of, and provide individual with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our phone number above.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____

Witness: _____

Date: _____