Patient Registration

CURRENT PATIENT INFORMATION— PLEASE PRINT

First Name: _____

Last Name: _____

Middle Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Sex: _____

Date of Birth: _____

Social Security No.: _____

Patient Email: _____

Required by government mandate:

Language: _____

Race: _____

Ethnicity: _____

Marital Status: _____

Guarantor Information (to whom statements are sent)

Name: _____

Address: _____

Relationship to patient: _____

Date of Birth: _____

Social Security No.: _____

Phone: _____

Emergency Contact Information

Name: _____

Relationship: _____

Phone: _____

Mobile Phone: _____

Employer Information

Employer: _____

Address: _____

Phone: _____

Other

Patient Referred by: _____

Primary Care Provider: _____

Contact Preference (circle one): Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name: _____

Crossroads: _____

Phone: _____

Primary Insurance Information

Insurance Plan Number: _____

Patient Insurance Number: _____

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex (please circle): **M** or **F**

Employer Name: _____

Patient's relationship to policy holder: _____

Secondary Insurance Information

Insurance Plan Number: _____

Patient Insurance Number: _____

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex (please circle): **M** or **F**

Employer Name: _____

Patient's relationship to policy holder: _____

To the best of my knowledge the above information is complete and accurate.

Signed: _____ **Date:** _____

****Please sign and date each item below****

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for PREMIER FAMILY PHYSICIANS**

Signed: _____ **Date:** _____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed: _____ **Date:** _____

- **I authorize PREMIER FAMILY PHSYICIANS to release medical information required to process my claim**

Signed: _____ **Date:** _____

- **I have read and understand the Finical Policy for PREMIER FAMILY PHYSICIANS**

Signed: _____ **Date:** _____

- **I authorize PREMIER FAMILY PHYSICIANS to obtain/have access to my medication history.**

Signed: _____ **Date:** _____

- **I authorize my provider's office to contact me by mobile phone**

Signed: _____ **Date:** _____

PATIENT AGREEMENT

Payment is due at time services are rendered. By signing below, you agree to and understand the following policies:

PFP Medical Care Agreement

I authorize the physicians of PFP to administer medical treatment as deemed necessary. I understand that there will be a $25.00 charge for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I also understand that PFP will not verify insurance coverage. I also understand the primary insured will be hold responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service, Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and adding benefits to otherwise payable to me to Premier Family, LLP.

_____

Initials

Provider Medical Care Agreement

I authorize the physicians of PFP to instruct their Physician Assistant/Nurse Practitioner and Physicals Medicine Providers to assist in certain aspects of my medical care.

I understand that a Physicians Assistant/Nurse Practitioner is not a licensed physician. They may treat or diagnose any illness or medical condition under the supervision of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility it is my responsibility to inform the staff of PFP if I wish not to see the Physicians Assistant/Nurse Practitioner and be scheduled with my assigned physicians accordingly. I understand that I may revoke this authorization at any time.

_____

Initials

Electronic Communication

By supplying my phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication**. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limit protected health voice mail or answering system if I am unavailable at the number provided by me.

_____

Initials

Policy and Fees

I understand the clinic normally use Clinical Pathology Laboratories. If I or my insurance company prefers another lab, it is my responsibility to inform a medical staff member before the specimen is collected so I am not billed for out of network lab. I understand there can be a fee for controlled substance prescriptions written without an appointment ($12).
I understand there may be a dee for missed appointments or appointment can cancelled within 24 hours. I understand there is a $35 fee for bounced checks and an additional $20 processing fee for balances going to collections. I understand there may be a fee for paperwork or forms completed without an appointment and may take up to 10 days to complete ($35-75).
I understand it may take up to 7 days to get lab results and 2 days to get imaging results.

Patient Name (please print): _____ DOB: _____

Patient Signature: _____ Date: _____

PATIENT BALANCE POLICY

All visits may be paid at the time of service and under no circumstances can we invoice them without accepting payment.

COPAY PATIENTS

Patients are required to pay copay at time of check-in.

DEDUCTIBLE PATIETNS

Patients are required to pay $85 at the time of check-in. Payment is preferred by credit and any adjustments can be made automatically, such as a different level office visit or patient deductible met.

In the instance a patient assures us they have met their deductible, but our system indicated otherwise, patient can be invoiced but we must take a credit card on file and notify the card will be charged if insurance indicates they have not met their deductible.

SELF-PAY / PRIVATE PAY

Patients are required to pay office visit at the time of service in the office per fee schedule provided. Credit cards must be on file for these patients to account for additional services that may be incurred during the visit.

CREDIT CARD AUTOMATIC PAYMENT/REFUND

Automatic payment allows Premier Family Physicians to charge your credit card for any out of packet not covered by insurance for all services provided by Premier Family Physicians. Your credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services billed or at time of service if not submitting to insurance. You will receive receipts detailing the amount charged and will receive notification prior to transaction, please contact us immediately for any questions or concerns. The limit per charge is $150 per visit for all services provided. Refunds will be issued automatically to this same card.

UNPAID BALANCES

Balances less than $200 must be paid at time of service.

Balances $200—$500 are permitted a payment plan of 2 months.

Balances $500—$1,000 are permitted a payment plan of 3 months.

Balances over $1,000 will require site administrator or CFO or COO to discuss with patient, CFO is to approve any payment plans discussed over $1,000.

NOTE: payment for current service is to be paid on top of the above. I.e. if payment has $85 deductible & $175 outstanding balance, the full amount must be paid at time of service due to balance being less than $200.

*UNDER NO CURCUMSTANCES WILL A PATIENT BE TURNED AWAY FOR REFUSING TO PAY. Upon refusal to pay for visit and/or balances, they must remain at the clinic to speak with Site Administrator (or CFO or COO) after their visit is complete, or schedule a time to discuss if too sick to remain at clinic, otherwise a block will be placed on their account and they will be unable to book future appointments.

PATIENTS AGE 18 OR OLDER

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

Patients Name: _____ Birthdate: _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for _____ to share my personal medical information to the following individual(s):

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Name: _____ Relationship to patient: _____ Phone: _____

Conditions for disclosure (Check the item(s) that apply):

☐ Premier Physicians may disclosure my medical information to individual(s) above when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Please note:

Premier Family Physicians will not disclose confidential information without a specific release. See release below:
I authorize the release of information relating to:

☐ Alcohol / Drug Abuse Evaluation/Treatment
☐ HIV / AIDS / STD Evaluation/Treatment
☐ Psychiatric Mental Health Evaluation/Treatment
☐ Pregnancy Evaluation/Treatment

Authorization:

- I authorize Premier Family Physicians to release the information marked above.
- I understand that when the health information is released, the information could be redisclosed by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that my health care and payment for health care will not be affected if I do not sign this form.

I understand this consent may be revoked by me at any time by written notice t o the practice.

Patient Signature: _____

Date of Signature: _____

Premier Family Physicians

Authorization for Release of Patient Information

Patient Name _____ **Date of Birth** _____

_____

Address **City** **State** **Zip**

Telephone Number(s) w=work, h=home, c =cell _____

Request Records from (Be sure to complete this section to prevent delays in obtaining your records):

Name of Doctor/Organization: _____ **Phone: (____)** _____ **Fax: (____)** _____

Address: _____

Description of information to be release: (please check all that apply)

__ Entire Record __ Immunization Records __ Laboratory Reports __ Radiology/Imaging Reports

__ Consultation __ Progress Notes __ Most recent history and physical

__ Other _____

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

This above information is to be disclosed to (please circle one):

Bee Cave	Dripping Springs	Lakeway	SW Medical Village	Westlake
12600 Hill Country Blvd	170 Benney Ln	101 Medical Parkway	5625 Eiger Road	912 S Capital of Texas Hwy
Ste R-103	Ste 200	Ste 210	Ste 200	Ste 100
Austin, TX 78738	Austin, TX 78620	Lakeway, TX 78738	Austin, TX 78735	Austin, TX 78746
Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668	Fax: 855.270.9668

Description or the purpose of the use and/or disclosure:

__ Continuing Care __ Second Opinion __ Social Security/Disability __ Personal Use

__ Consultation/Referral __ Insurance __ Legal Purposes

__ Other; Please Describe _____

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipet and may no longer be protected by federal and state privacy regulations. I understand Premier Family Physicians has fees for the type of records provided. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date of event).

I understand I may revoke this authorization at any time by notifying Premier Family Physicians. I understand that if I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

X _____ _____ _____

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