

****Please review and update the information below to the best of your ability.****

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
 First Name:
 Middle Name:
 Address:
 City: State: Zip:
 Home Phone:
 Work Phone:
 Mobile Phone:
 Sex: **F**
 Date of Birth:
 Social Security No.:
 Patient email:
 Required by government mandate [although you may refuse]:
 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

Pharmacy Information:

Patient Referred by:

Name:

Primary Care Provider:

Crossroads:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Phone:

Primary Insurance Information

Insurance Plan Name: ***SELF PAY***
 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 Name:
 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 PHYSICIANS to release medical information required to process my claim

Signed _____ Date: _____

- I have read and understand the Financial 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 held 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 assign benefits to otherwise payable to me to Premier Family Physicians, LLP.

Initials

Provider Medical Care Agreement

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

I understand that a Physician 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 to inform the staff of PFP if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduled with my assigned physician 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, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my 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 fee 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 must 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 PATIENTS

Patients are required to pay \$85 at the time of check-in. Payment is preferred by credit card 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 indicates 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 pocket 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 CIRCUMSTANCES 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.

Southwest Medical Village, and Corporate Headquarters, 5625 Eiger Road, Suite 200, Austin Texas 78735. PH: 512 892 7076

Westlake, 912 South Capital of Texas Hwy, Austin Texas 78746. PH: 512 306 8360

Bee Cave Galleria, 12600 Hill Country Blvd, Building R Suite 103, Bee Cave Texas 78738. PH: 512 358 8180

Dripping Springs, 170 Benney Lane, Suite 200 78620, Dripping Springs Texas 78620. PH: 512 858 2997

**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 _____ and his/her staff to disclose my personal medical information to the following individual(s):

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 disclose my medical information to individual(s) above when I am not physically present, including disclosures by telephone, fax, 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 to the practice.

**Patient
Signature/Personal
Representative:** _____

Date of Signature: _____

**Description of
Representative's
Authority:** _____

Pediatric Health History Form**Allergies:** (Include Drug, Reaction, and Age of Onset):

*please note if allergies were tested by blood or skin testing

Medication/Drug Allergies (list type of reaction) _____

Food Allergies (Do you carry a current epipen?) _____

Seasonal Allergies: _____

Current Problems:**History:****Birth History:**

Age of Mom: _____

Birth Weight: _____

Discharge Weight: _____

Gestational Age at Birth (weeks): _____

Duration of Labor: _____

Delivery Method Vaginal C-Section
If C-Section why? _____

Complications during pregnancy (diabetes, infections, high blood pressure, breech presentation) _____

Alcohol/Drug/Cigarette/Medications during pregnancy _____

Problems with baby in the nursery? _____

Did baby go home with mom? _____

APGAR 1m: _____

APGAR 5m: _____

APGAR 10m: _____

Infant Feeding: Breast Bottle Both

Formula Name? _____

Comments: Newborn Hearing Screening Pass Fail Other Comments: _____

Medical History: (Check Appropriate Box and Comment in Margins)

ADD/ADHD _____
 Anemia _____
 Congenital Heart Disease _____
 Developmental delay _____
 Eczema _____
 GE Reflux _____
 Murmur _____
 Recurrent Otitis (ear infections) _____
 Seizures _____
 UTI _____
 Vesicoureteral Reflux _____
 Autism/Asperger's Disorder _____
 Learning Problems _____
 Chronic abdominal pain _____

| | |
|-----|----|
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |

Allergic Rhinitis _____
 Asthma _____
 Constipation _____
 Diabetes _____
 Mental Illness _____
 Recurrent Strep Throat _____
 Vision Problems _____
 Wheezing/RSV/Bronchiolitis _____
 Concussion _____
 Failure to thrive/poor growth _____
 Headache _____

| | |
|-----|----|
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |
| Yes | No |

Please list any specialists who your child sees and reason if not listed above _____

Other Medical History: _____

| Surgical History: Check Appropriate Box | Yes | No | Date | Surgeon |
|--|------------|-----------|-------------|----------------|
| Adenoidectomy (adenoids removal) | | | | |
| Appendectomy (appendix removal) | | | | |
| Ear Tubes | | | | |
| Heart Surgery | | | | |
| Hernia Repair | | | | |
| Orthopedic Surgery | | | | |
| Tonsillectomy | | | | |
| Urologic Surgery _ | | | | |

Other Surgical History: _____

Please list any hospitalizations and approximate date if not listed above _____

Any previous adverse reaction to vaccines? _____

Immunizations up to date? _____

Please list current prescriptions and over the counter medication and dosage _____

List below any of child's relatives (mother, father, siblings, grandparents, aunts, uncles) who have had the following illnesses.

| CONDITION | NO | YES | FAMILY MEMBER |
|----------------------------------|-----------|------------|----------------------|
| Allergies | | | |
| Anemia | | | |
| Arthritis | | | |
| Asthma, Emphysema, T.B. | | | |
| Birth Defects | | | |
| Blood Disease | | | |
| Bone/Muscle Disease | | | |
| Cancer (specify) | | | |
| Cystic Fibrosis | | | |
| Diabetes () Adult () Juvenile | | | |
| Drug / Alcohol Abuse | | | |
| Eye / Ear Disorders | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| Infections (Frequent / Severe | | | |
| Kidney / Liver Disease | | | |
| Learning Problems | | | |
| Mental Illness / Retardation | | | |
| Metabolic / Genetic Disease | | | |
| Nerve Disorder (Epilepsy, C.P | | | |
| Rheumatic Fever | | | |
| Sickle Cell Trait / Disease | | | |
| TB or Exposure | | | |
| Thyroid Disease | | | |
| Autoimmune Disease | | | |
| Skin Disease (eczema, psoriasis) | | | |
| Heart Attack < 50 years old | | | |

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (IMT)
MINOR CONSENT FORM

ImmTrac
Texas Immunization Registry

(Please print clearly)

Child's Last Name

For Clinic/Office Use

Child's First Name

Child's Middle Name

**Children under 18 years only*

Child's Gender: F

Child's Date of Birth

Child's Address

Apartment #

Telephone

City

State

Zip Code

Country

Mother's First Name

Mother's Maiden Name

IMT, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in IMT. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorize Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("IMT"). Once in IMT, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the IMT Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, IMT Group - MC 1946, R.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.
Parent, legal guardian or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Upon completion, please fax or mail form to the DSHS IMT Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.IMT.com

Texas Department of State Health Services • IMT Group - MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EC-7

Revised 05/18/2012



PROVIDERS REGISTERED WITH IMT - Please enter client information in IMT and affirm that consent has been granted.
DO NOT fax to IMT. Retain this form in your client's record.

Your Family Tree

Please help us to understand your family tree so we can ensure that we are all communicating effectively.

| Who accompanies the child to today's visit? Name | Relationship to Child |
|---|-----------------------|
| <hr/> | <hr/> |

List ALL family members who live in the child's primary household below. Indicate relationship of each member to your child (including step parents, grandparents and step/half siblings).

| Name | Relationship to Child |
|-------|-----------------------|
| <hr/> | <hr/> |
| <hr/> | <hr/> |
| <hr/> | <hr/> |
| <hr/> | <hr/> |
| <hr/> | <hr/> |
| <hr/> | <hr/> |

List full names of biological parents below (if not listed above)

If your child does have a relationship with a biological parent who does not live in the home, please describe their relationship below. Please provide their legal name, address and phone number if they are involved in medical decision making. Please also provide their spouse's information if applicable, and if this person is authorized to participate in the child's medical care.

If there is legal documentation of decision-making power regarding the child's medical and health care, please provide our office with that documentation.

Premier Family Physicians
Authorization for Release of Patient Information

Patient Name _____ Date of Birth _____

Address _____ City _____ City _____ Zip _____

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

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 released: (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):

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