PATIENT INFORMATION

Name: _____
(Last) (First) (Middle) (Suffix)

Sex: Male Female Date of Birth: _____ Social Security Number: _____

Mailing Address: _____City: _____State: _____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Marital Status: Single Married Separated Divorced Widow/Widower

Employed: Yes No Occupation: _____

Employer's Name and Address: _____

BILLING INFORMATION

Person Responsible for paying bill: Self Parent Spouse Other: _____

Name (if different from above):_____ Date of Birth: _____
(Last) (First) (Middle)

Address (if different from above):_____

Social Security Number: _____ Best Contact Number: _____

Employer's Name and Address: _____

Please bring your driver license and insurance cards to your appointment

EMERGENCY CONTACT

Person to Contact in Case of Emergency**:**

Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ Relationship: _____

PRACTICE INFORMATION

Referring Provider**:** _____

How did you hear about us?: (please circle one) Advertising Primary Care Physician Specialist Physician

Word of Mouth Patient in Practice Hospital Insurance Company

Do you currently have a living will? _____Yes _____No (If yes, please provide a copy for our medical records)

Preferred Pharmacy: _____

Are you a member of either of the following groups: Senior Circle Healthy Woman

May we call you to discuss your satisfaction regarding your office visit: Yes No

RACE AND ETHNICITY

Race: White African American American Indian European Other:
_____

Ethnicity: Central American Cuban Dominican Hispanic or Latino/Spanish Latin American/Latin, Latino Mexican
Not Hispanic or Latino Puerto Rican South American Spaniard

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL/INSURANCE AGREEMENTS:
Please initial:

_____ In the event I have no insurance coverage, I understand that I am responsible for payment of services rendered to me or my dependents at the time of service. I understand if I fail to pay amounts owed: the clinic has the right to secure an outside collection agency and/ or attorney to collect the unpaid debt and to report the unpaid debt to a credit- reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees. I herby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or to me. I understand I am responsible **at the time of service** for paying any required co-payment and deductible.

I have read and understand the payment policy of this office and agree to abide by the said policy. I understand a $30.00 charge will be assessed on all returned checks.

_____ _____ _____

Patient / Parent / Guardian Relationship to Patient Date

HIPAA

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

Your rights are posted in the waiting rooms at each Star Family Medicine. Copies of the rights are also available at the receptionist desk if you would like to keep this information for your records**.**

I authorize Star Family Medicine to release any of my medical or insurance information necessary to process my medical claims and coordinate/manage my healthcare.

With whom may we discuss information about your care, treatment or diagnosis?

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

I acknowledge the HIPAA Patient Rights and Privacy forms. I have read and understand my rights.

_____ _____

Signature (Patient or Patient if Minor) Printed Name

_____

Date

ELECTRONIC MEDICAL RECORDS HISTORY

Star Family Medicine utilize an Electronic Medical Records (EMR) System in our office.

- We now have the ability to check your prescription eligibility and download your pharmacy history into our system.
- We also have the added ability to fax mail order prescriptions, review prescription benefits, and drug formulary all while you are in our office.

By signing below, you are granting Star Family Medicine permission to obtain this information on your behalf.

I, the patient/parent of a minor, give my consent to Star Family Medicine to obtain my pharmacy benefits.

_____ _____ _____

Signature Printed Name Date

Medical Records Request Form

All portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health insurance Portability Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name _____ Date of Birth _____ Social Security Number _____

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to Release my Health Information _____

Agency or Individual(s) Authorized to Receive my Health Information _____

Address: City, State, Zip _____ Telephone Number _____

Health information that may be used/disclosed is limited to the following:

O Progress Notes O History & Physical O Operative Note(s) O Emergency Room Report O Consultation(s)
O Imaging/X-ray O Lab O Discharge Summary O Pathology Report O Entire Record
O Other (specify) _____

Health information that may be used/disclosed is limited to the following treatment dates:
_____

Health information to be released to the above named agency/individual is to be used/disclosed for the following purpose(s):
_____

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. Information may include, but is not limited to medical records, x-ray films, slides, tracings, strips, ect.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, **to include alcohol, drug abuse, communicable disease including HIV status**, **and/or psychiatric diagnoses** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above. O Yes O No

Protected Health Information used to disclose pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply. This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of the specified event. I understand that I have a right to revoke this authorization at anytime; in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Insurance Portability Accountability Act prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Information Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Representative's Signature _____ Date _____ Time _____

Relationship to Patient/Authority to Act on Patient's Behalf _____ Witness's Signature _____ Expiration Date or Event _____

General Patient Information

Thank you for choosing Star Family Medicine as your healthcare provider. We are committed to providing you with quality, affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this. Please review and ask us any questions you may have.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible at each visit.

3. **Non-covered services.** Please be aware that some or all of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit and a signature is required from you prior to services being rendered.

4. **Proof of insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments.** The staff at Star Family Medicine understands that certain circumstances require rescheduling of an appointment. However, three or more "no shows" may result in a patient being discharged from the provider. A "no show" is defined as when a patient misses an appointment and has not called prior to the appointment time to reschedule, or is more than 15 minutes late. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. A charge of $35.00 may be billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.
    * Medicare recipients are exempt from the missed appointment charge.
    * If you are a Medicaid recipient your health care plan will be notified of any and all missed appointments
    * If 3 or more appointments are missed you may be placed on a work in only list or even discharged from your assigned practice.

9. **Date/Time of Appointment.** Patients will be called back according to their scheduled appointment time by healthcare provider. Every effort is made to assure that patients are seen as close to their scheduled appointment time as possible. Patients whose symptoms are severe, infectious, or change dramatically while waiting may be taken to a patient room as soon as possible for their appointment. We appreciate your understanding at all times.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

GENERAL AUTHORIZATION FOR TREATMENT/CONTACT

I authorize physicians, nurse practitioners, mid wives and/or physician assistants of **Star Family Medicine** who may attend me, their assistants, including those employed by **Star Family Medicine** to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my provider. These services may include pathology, radiology, emergency services and other special services ordered by my provider. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider to examine, use, store, and/or dispose of in any manner (except for organ donation and/or transplantation) any tissue, fluids or parts removed from my body. In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.
_____ (initials)

I authorize **Star Family Medicine** to contact me on any cell phone number provided by me for the purposes of conducting business with me or contacting me concerning my account. I consent to the use of automated dialers for that purpose.
_____ (initials)

I consent and give permission to **Star Family Medicine** to photograph me for internal purposes of patient identification only. This photograph will not be used for marketing purposes without the patient's expressed consent.

RELEASE AND ASSIGNMENT OF BENEFITS

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to (1) an insurance company through which I claim benefits and (2) any physician involved in my medical care. I realize the authorization allows Star Family Medicine to release any information to any of my insurers or physicians. I authorize and direct my insurers to pay directly to Star Family Medicine and/or its physicians any and all benefits up to the amount of my bill pertaining to all charges incurred. I assign to Star Family Medicine, including its affiliates, any and all benefits or proceeds, of any type whatsoever, to which I am entitled, with respect to the health care service(s) I receive, including but not limited to, the proceeds of any liability settlement or judgment being paid by or on behalf of a third-party and any benefits due from any third-party insurance policy. I direct that all such benefits be paid directly to Star Family Medicine and/or its affiliates, including its physicians, and applied to my account(s) until the account(s) is paid in full. I understand that I am personally responsible for any remaining fees.

I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney for collection.
_____ (initials)

Print Patient Name:_____ DOB: _____

Patient Signature:_____ _____ Date: _____

Responsible Party Signature (if different):_____ Date: _____

IMMUNIZATION REGISTRY AND HEALTH INFORMATION EXCHANGE

It has been explained to me that Star Family Medicine participates in an Immunization Registry and Health Information Exchange with the TX. Department of Health and Family Services I understand this is a statewide, confidential database of patient immunization information and that my personal protected health information will be included in this database (please initial your preference from the 4 choices below):

___ I hereby consent to opt in/ participate in and authorize the use of my health information in the Immunization Registry as deemed appropriate by my health care providers.

____I hereby wish to opt out of participation in the Immunization Registry.

____I hereby consent to opt in/ participate in and authorize the use of my health information in the Health Information Exchange as deemed appropriate by my health care providers.

___ I hereby wish to opt out of participation in the Health Information Exchange.

Print Patient Name:_____ DOB: _____

Patient Signature:_____ _____ Date: _____

Responsible Party Signature (if different):_____ Date: _____

Consent to Treat Minor

I,_____(Parent/Legal Guardian Name) by signing this form, do acknowledge that _____(Name of Patient) is considered a minor in the state of Texas and that I have the right to consent to his/her treatment in all forms. I hereby consent to and authorize the diagnostic procedures, treatments or both as advisable to maintain his/her health and well -being and to assess, evaluate and treat his/her injury or illness. I understand that the provider responsible for my child's care has the responsibility to explain to me the purpose, benefits and most common risks involved in the diagnosis and treatment of his/her illness or injury, as well as alternative available course of treatment. By signing this document, I am stating the above name minor child:

_____ **May** receive medical care and treatment **without** myself or another legal guardian/representative present with them.

_____**May NOT** receive medical care and treatment without myself or another legal guardian/representative present with them.

_____**May receive medical care and treatment without myself present, but only with the following listed adult representative(s) present in my absence:**

_____(Name of adult representative)_____(relationship to patient)

_____(Name of adult representative)_____(relationship to patient)

_____(Name of adult representative)_____(relationship to patient)

_____(Signature of Consenting Parent/Legal Guardian)

_____(Printed name of of Consenting Parent/Legal Guardian)

_____(Relationship to child)

_____(Date)

_____(Witness Signature)

_____(Witness Printed Name)

_____(Date)