Patient Registration

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security No: _____ Sex: ☐ *Male* ☐ *Female*

Home Phone: _____ Mobile / Cell: _____

Email Address: _____

Mailing Address: _____
Street *City* *State* *Zip*

Emergency Contact: _____
Name *Phone Number* *Relationship*

DEMOGRAPHICS

Ethnicity: ☐ *Not Hispanic* ☐ *Hispanic/Latino* ☐ *Decline*

Race: ☐ *White/Caucasian* ☐ *Hispanic/Latino* ☐ *Black/African-American*

☐ *Asian* ☐ *Decline* ☐ *Other* _____

INSURANCE INFORMATION

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Company: _____	Insurance Company: _____
Policy No./Member ID: _____	Policy No./Member ID: _____
Group No.: _____	Group No.: _____
Policy Holder Name: _____	Policy Holder Name: _____
Relationship to Insured: ☐ *Self* ☐ *Spouse*	Relationship to Insured: ☐ *Self* ☐ *Spouse*

CONSENT

I certify that I have carefully reviewed this document, understand it, and have completed it truthfully.

Patient Signature: _____ Date: _____

Name Printed: _____

4347 Phelan, Suite 101, Beaumont, TX 77707
Phone: 409.767.9285 Fax: 409.332.4104

Patient Health Questionnaire

Patient Name: _____ Date of Birth: _____

MEDICATIONS

List all current medications (including OTC medications and vitamins). Include the dosage and frequency taken.

_____

_____

_____

Drug Allergies: _____

MEDICAL HISTORY

Check All That Apply:

☐ Anemia	☐ COPD	☐ Heart Disease	☐ Osteoarthritis
☐ Anxiety	☐ Dementia	☐ Heart Attack	☐ Osteoporosis
☐ Arrhythmia	☐ Depression	☐ Hepatitis	☐ Parkinson's
☐ Arthritis	☐ Diabetes	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Asthma	☐ Diverticulosis	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Atrial Fibrillation	☐ DVT (blood clot)	☐ HIV	☐ Seizure Disorder
☐ Bipolar	☐ GERD	☐ Kidney Disease	☐ Stroke
☐ Cancer _____	☐ G.I. Bleed	☐ Kidney Stones	☐ Thyroid Disorder
☐ Crohn's Disease	☐ Glaucoma	☐ Liver Disease	☐ Tuberculosis

Other Medical Issues Not Listed: _____

_____

Hospitalizations and/or Surgical History: _____

_____

_____

PROVIDERS

List your primary care primary (PCP) and any other medical providers and specialists you see on a regular basis.

Physician / PCP: _____ Date of Last Visit: _____

Other medical providers and/or specialists: _____

_____

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Patient Consents & Acknowledgment

GENERAL CONSENT TO CARE

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Primary Care Anywhere on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Primary Care Anywhere is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Primary Care Anywhere facilities.

NOTICE PRIVACY ACKNOWLEDGMENT

Primary Care Anywhere "Notice of Privacy Practices" provides information about how *Primary Care Anywhere* may use and disclose your protected health information. You have the right to review the Notice before signing this acknowledgment. A copy of the current Notice will be provided to you at your request. The Notice contains the effective date and as provided in our Notice, the terms of our Notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made disclosures on your prior consent. This Privacy Acknowledgement does not give us consent to release records to anyone except to whom is mentioned. A signed medical release authorization form must be completed prior to us releasing records on your behalf.

TELEMEDICINE

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

TO THE PATIENT

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

SIGNED CONSENT

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Name Printed: _____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Chronic Care Management (CCM) Consent

By signing this Agreement, you consent to Primary Care Anywhere (referred to as "PCA"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in PCA's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings.

PCA will discuss with you the specific services that will be available to you and how to access those services.

CCM COSTS

ONLY your insurance will be charged and you will <u>NOT</u> be charged to apply or receive any CCM Services.

PCA OBLIGATIONS

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

BENEFICIARY RIGHTS

You have the following rights with respect to CCM Services:

- PCA will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the current month. You may revoke this agreement verbally (by calling 409.767.9285) or in writing to (4347 Phelan Blvd, Ste 100, Beaumont, TX 77707).

- Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

SIGNED CONSENT

I agree to participate in the Chronic Care Management program. ❑ Yes ❑ No ❑ NA

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.

Patient/Representative: _____ Date: _____

Signature: _____

Patient Responsibility

Thank you for choosing *Primary Care Anywhere* (PCA) for all your medical needs. We look forward to providing you a complete package of medical treatment. We file your charges to your insurance carrier as a benefit to you. It is, however, the patient's responsibility to know & understand what service is covered under the policy. In order to help keep healthcare costs down, we ask the following payments be made on your account prior to being seen by your medical provider. For your convenience we do accept cash, check and most all major credit cards. There is a $25 return check fee.

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay $100.00 for the medical services rendered to me at time of service.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to *Primary Care Anywhere* on my behalf for any services furnished to me by the providers.

CREDIT CARD AUTHORIZATION

I agree and understand that my credit card (listed below) may be charged the amount of my co-pay, coinsurance, or $100.00 after my visit depending on my insurance coverage- or lack thereof.

Name on Credit Card: _____

Credit Card No: _____

Expiration Date: _____

CVV2: _____

Zip Code: _____

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Patient Responsibility *page 2*

SIGNED CONSENT

I have read & understand my financial obligations. I understand that this office will file an insurance claim on my behalf based on the information I provide. Both *Primary Care Anywhere* (PCA) and I will receive an EOB (explanation of benefits) from my insurance carrier(s) that will detail any payments, deductions & adjustment per my plan's guidelines. I understand that I will be fully responsible for payment of any & all medical services denied by my insurance company as applicable by state and/or federal law.

Patient Signature: _____ Date: _____

Name Printed: _____