THPG PATIENT REGISTRATION

PATIENT DEMOGRAPHICS

DATE:_____

Legal Name: First_____ MI_____ Last_____ Preferred First Name: _____

Parent/Legal Guardian Name_____ DOB_____ Mobile_____

SS#_____ Sex: □ M □ F DOB:_____

Address:_____ Apt #_____ City_____ State_____ Zip _____

Phone: Home_____ Work_____ Mobile_____

E-Mail_____ □ No Email

GENERAL INFORMATION

Marital Status: □ Divorced □ Legally Separated □ Married □ Significant Other □ Single □ Widowed

Need Interpreter □ Yes □ No Preferred Language_____ Written Language_____

Race: □ Asian □ Black □ Native American □ Native Hawaiian/Pacific Islander □ Two or More Races □ White

Ethnicity: □ Hispanic □ Non-Hispanic

ADDITIONAL DEMOGRAPHICS

Preferred Communication Method: □ No Preference □ Mail □ Phone □ E-mail □ My Chart □ Accept Text Messages
By checking one of the boxes for Preferred Communication Method, I agree to receiving correspondence from THPG

Do you have any communication difficulties/ special needs? Visually Impaired □ Yes □ No Hearing Impaired □ Yes □ No Special Needs □ Yes □ No

If yes, please list: _____

PCP

Primary Care Physican_____ □ No Primary Care Physician

EMERGENCY CONTACTS

Name_____ Rel to Patient_____ Home Phone_____ Mobile_____

Name_____ Rel to Patient_____ Home Phone_____ Mobile_____

EMPLOYMENT

Employer Name_____ Employment Status: □ Disabled □ Full Time □ Part Time □ Retired □ Student □ Unemployed

FOR OFFICE USE ONLY:

*Patient Name*_____

*MRN*_____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Texas Health Physicians Group and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Texas Health Physicians Group of changes or update. I authorize Texas Health Physicians Group to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

☐ **Only Release Information to Patient**

If *no* answer, may we leave a message for you on your Home Phone: □ Y □ N Work: □ Y □ N Mobile: □ Y □ N

Name_____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: ☐ **Appointments** ☐ **Billing** ☐ **Medical Care**

Name_____ Relationship to Patient_____

Home Phone_____ May We Leave a Message? □ Y □ N Mobile_____ May We Leave a Message? □ Y □ N

You may release the information regarding the following services to the person named above: ☐ **Appointments** ☐ **Billing** ☐ **Medical Care**

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet.

Initials _____

FINANCIALLY RESPONSIBLE PARTY – GUARANTOR

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____ MI_____ Last_____ DOB_____

Relationship: Spouse Father Mother Other (Please Specify): _____

Address:_____ Apt #_____ City_____ St_____ Zip_____

Phone: Home_____ Cell_____ Work_____

Employer Name_____ Employment Status: □ Student □ Part Time □ Full Time □ Retired □ Disabled □ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID_____ Gp _____

Subscriber Name_____ Sex: □ M □ F Patient Relationship to Subscriber_____

Subscriber's DOB_____ Employer_____ Employment Status: □ Part Time □ Full Time □ Retired □ Disabled □ Unemployed

SECONDARY INSURANCE_____ ID:_____ Gp _____

Subscriber Name_____ Sex: □ M □ F Patient Relationship to Subscriber_____

Subscriber's DOB_____ Employer_____ Employment Status: □ Part Time □ Full Time □ Retired □ Disabled

□ Unemployed

FOR OFFICE USE ONLY:

*Patient Name*_____
*MRN*_____

HOW YOU HEARD ABOUT US

□ Family/Friend □ Email □ Newspaper / Magazine Ad □ Organization Website □ Internet Search □ Television Commercial □ Organization Newsletter

□ Other_____ □ Referring Physician_____ □ Coach_____ □ Trainer_____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

- ☐ I authorize direct payment of my insurance benefits to Texas Health Physicians Group for services rendered to myself or dependents.
- ☐ Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- ☐ Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- ☐ Out of Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- ☐ Texas Health Physicians Group or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.
- ☐ I hereby consent to credit bureau inquiries and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process. I understand that these collection attempts could be performed by from Texas Health Resources or its affiliates/agents including, without limitation, any account management companies, independent contractors or collection agents.

Lab / X-Ray / Diagnostic Services:

- ☐ I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- ☐ I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
- ☐ I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- ☐ I further authorize and request that insurance payments be directed to Texas Health Physicians Group

Authorization to Treat a Minor (Ages 0-18th Birthday)

☐ **Not Applicable (patient is an adult)**

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Texas Health Physicians Group to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Texas Health Physicians Group of changes or update. I authorize Texas Health Physicians Group to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

PRIVACY PRACTICES

THPG offices, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT

I have read, fully understand and agree to the above **release of medical information to others, financial and payment guideline, release of information & assignment of benefits, authorization to treat a minor and privacy practices**. I also certify that all of the information, provided is complete and accurate.

Patient Name_____ Signature_____ Date_____

Health Information Exchange Authorization

_____ participates in health information exchanges as described in the Texas Health Resources Health Information Exchange Patient's
(physician/clinic/facility name)
Frequently Asked Questions document which may be revised at any time.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which THPG participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.

I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing.

The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

Hospital Visit for Obstetric patients only: I also give this authorization for any child(ren) born to me during this visit.

I authorize release of my medical information to the Health Information Exchanges in which THPG participates:

_____Yes_____No

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

Print Patient's Name	Date of Birth	Address
Signature of patient or authorized representative	Relationship to patient or self	Date
Witness	Title	Date

A "legally authorized representative" is; 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian or a minor, or 6) a person authorized under the Texas Consent To Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release of any information.

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Consent to Treat

I hereby authorize employees and agents of Texas Health Physicians Group (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Today's Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian (if different than patient) _____

Patient or Legal Guardian Signature _____

Last updated 3/16/18