Rios Family Medicine Clinic, P.A.

WELCOME TO OUR OFFICE
NEW MINOR/STUDENT PATIENT CONSENT FORMS

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Information On Patient

Patient Name:______________________________ Date: ___/___/_____
First Name Last Name MI

Sex: M❑ / F❑ Date Of Birth: ___/___/______ SS # ______-_____-_________

Home Address: ____

City: ______________________________ State: ___________ ZIP: _________________

E-Mail:_________________________@______________.com Cell Phone: (_____)_______-__________

School Name:_________________________________ ____ Home Phone: (_____)______-_________

Race: ______________ Ethnicity:_______________ Language Of Preference:______________________

Father Name: ____________________ DOB: ___/___/______ Father's Phone :(_____)_______-__________

Occupation ___________________________ Employer Address:_________________________________

Employer ____Work Number: (_____)_______-__________

*Mother Name:*____________________ DOB: ___/___/______Mother's Phone:(_____)_______-__________

Occupation ___________________________ Employer:_____________________________________

Address: ____Work Number: (_____)_______-__________

Information on party responsible for payment

❑ Check here if this information is the same as in the box above.

Name:____

Date Of Birth: ___/___/_____ SS # ______-_____-____________ Home Phone:(_____)______-_________

Home Address: ____

City: ______________________________ State: ___________ Zip: ________________

Employer:____ Work Phone: (_____)_______-_________

Relationship To Patient: ____

Insurance information

1st Insurance Company	Policy #	Group #	Insured's Name	Date Of Birth
2nd Insurance Company	Policy #	Group #	Insured's Name	Date Of Birth

I agree to be responsible for any charges for services and materials supplied by **Rios Family Medicine Clinic, PA** and its doctors for the above patient. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to my Insurance carrier for payment to me. I also authorize the release of any medical or information necessary to process my claim. I also authorize the release of any medical information to my school, employer, department of public safety, or any other physician or medical facility involved in my medical care.

____ ___/___/______

Signature Of Party Responsible For Payment Date

Rios Family Medicine Clinic, P.A.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM HIPAA

I acknowledge that I have received a copy of the **Rios Family Medicine Clinic, PA** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

1. ____/____/______

Patient acknowledgement (Signature) Date

Medicare lifetime consent: I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

2. ____/____/______

Signature Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from **Rios Family Medicine Clinic, PA**, may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Rios Family Medicine Clinic, PA**. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me. While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **Rios Family Medicine Clinic, PA** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **Rios Family Medicine Clinic, PA** to restrict how my health information is used or disclosed. **Rios Family Medicine Clinic, PA** does not have to agree to my request for the restriction, but if **Rios Family Medicine Clinic, PA** does agree, **Rios Family Medicine Clinic, PA** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **Rios Family Medicine Clinic, PA** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

3.____/____/_________

Signature Date

Rios Family Medicine Clinic, P.A.

HIPAA PRIVACY POLICY: ACKNOWLEDGEMENT OF RECEIPT

The **Rios Family Medicine Clinic, PA** Notice of Privacy Practices provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient.
I, ___________________________________ , have received a copy of the **Rios Family Medicine Clinic, PA** Notice of Privacy Practices.
I choose to designate the individuals listed below as my primary contacts. **Rios Family Medicine Clinic, PA** personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's name ________________________________ Patient's DOB ___/____/_______

#1 Contact Name ____ DOB ___/____/_______

Contact Phone (______)______-___________ Relationship _______________

#2 Contact Name ____ DOB ___/____/_______

Contact Phone (______)______-___________ Relationship ________________

Signature ____ Date ___/____/_______
(Patient Parent, Authorized Representative)

This Contact in Case of Emergency, Not a part of the HIPPAA Privacy Contact

Next Of Kin Name ____
Relationship ____________________

Contact Phone_____________________________________

* *

Inability to obtain acknowledgement
To be completed by **Rios Family Medicine Clinic, PA** representative ____________________________
It was not possible to obtain the individual's acknowledgement for the following reason(s):
_____ Emergency situation
_____ Patient physically unable to sign
_____ Patient refused
_____ Patient left office prior to obtaining signature
_____ Other reasons (list below)

Patient name ____
Comments ____

Signature of representative ______________________________ Date ________________

Rios Family Medicine Clinic, P.A.

Name (Mr/Mrs/Miss/Dr) ____
Last name First name MI

REASON FOR TODAY'S VISIT Today's Date:_____/_____/_________
(ie: headache, seizures, cough)

____

____

____

ALLERGIES:____

____

MEDICATIONS	NAME	DOSE	FREQUENCY	START DATE

I HEAR BY STATE THAT MY VISIT WITH DR RIOS IS NOT FOR

I. A WORK RELATED INJURY
II. A MOTOR VEHICLE ACCIDENT
III. CHRONIC PAIN MANAGEMENT.

____/______/______________
Patient Signature Date

Rios Family Medicine Clinic, P.A.

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Rios Family Medicine Clinic, P.A. as your healthcare provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. In order to keep your cost of healthcare to an absolute minimum, we have adopted the following policies.

Fees and Payments: Fees are standardized and are based on the complexity of your visit. Payment in full is required at the time of service and can be made with cash, personal check, money order, Visa, MasterCard, Discover, or American Express.

Insurance Plans: Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize that as healthcare provider, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify we are participants in your plan and the services you intend to receive are covered. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In order for us to file your claim, you must present a current copy of your insurance card at each visit and communicate any changes in your personal contact information.

Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co- payments, coinsurance, or deductibles. Co-payments are due when you check in for your appointment. We cannot waive co-payments, nor do we bill for co-payments.

The new Affordable Care Act Insurance (Obama Care) " Blue Cross Blue Shield of Texas " allows for 90 day grace period. If you cancel or change your insurance **you will be responsible and will have to pay for all services given in during that time.** Our clinic is required to return any payment made to us by the insurance company and then we are required to collect that amount form the patient.

Not all services are covered benefits in all policies, so it is very important that you understand the provisions of your policy. Some insurance companies arbitrarily select certain services they will not cover, and so we cannot guarantee payment of all claims by your insurance company. Some insurance plans do not cover any preventative care. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits (EOB). **Reduction or rejection of your claim by your insurance company does not relieve you of your financial responsibility**. Please be advised that we cannot and will not change records after your visit. The diagnosis established at the time of your visit is what will be billed to your insurance.

Self-pay: Patients without insurance are considered self-pay patients. When possible, a fee range will be given upon check-in or when you make your appointment, along with any anticipated additional charges. The full cost of the visit is due at the time of service.

Minors: The parent(s) or guardian(s) of a minor is responsible for providing current insurance information for the minor and/or payment in full for services provided.
Unaccompanied minors must have authorization for medical treatment signed by a parent or guardian and is responsible for current insurance information for self and/or payment in full for services provided

Rios Family Medicine Clinic, P.A.

Miscellaneous Charges: Returned check charge for non-sufficient funds is subject to a $35.00 fee in addition to fees from your bank. Missed Appointments - If you miss an appointment and have not called to cancel that appointment, a $25 "no show" fee will be charged.

Laboratory charges are not included in the cost of your care. You will get a separate bill from the lab. Please contact the laboratory facility directly to discuss any questions with your bill.

Collections charges - Accounts that are not paid in the agreed upon time will be sent to an external collections agency and reported to the credit bureau. In addition to the outstanding balance, a 33% surcharge will be added to cover our costs. You may be dismissed from the practice.

Medical Records Charge -The cost of copying records is $25.00 for the first 25 pages and $.17 per page after 25.

Form completion - The cost for completion of forms is $20.00 per form. Please allow a 72 hour turnaround for any forms to be prepared.

I have read and understand the above terms and conditions and will verify so by giving my signature.

____/______/___________

Signature Date

Statement of Coverage: I hereby attest that I do not have additional healthcare coverage afforded to me other than the primary insurance supplied by myself or legal guardian at the time of my appointment.

____/______/____________

Signature Date

Rios Family Medicine Clinic, P.A.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFROMATION.

PLEASE REVIEW IT CAREFULLY

- Confidential medical information may be disclosed, without the patient's consent or authorization, as needed for treatment, payment, or healthcare operations.
  - "Treatment" includes:
    - The provision, coordination, or management of health care and related services among health care providers regarding a patient: or,
    - The referral of a patient from one health care provider to another.
  - "Payment" includes:
    - To obtain payment for the provision of healthcare.
  - "Healthcare Operations" includes:
    - Quality improvement
    - Clinical guideline development
    - Reviewing the competence and performance of health care professionals
    - Training students and residents
    - Legal and accounting services
    - Business plan development
- Other situations in which information may be disclosed without the patient's consent o To a public health authority that is authorized by law to collect and receive information related to the prevention or control of disease, injury or disability
  - To a government authority responsible for cases of child abuse or neglect o To the FDA as it relates to adverse events, product defects or problems
- Any use of medical information, other than what is described above, will require a patient's written authorization, and that authorization may be revoked by giving written notice
- PATIENTS RIGHTS
  - Request additional restrictions on the use of their healthcare information, although the physician does not have to agree to these additional restrictions.
  - Specify the manner in which the physician is permitted to communicate with them o Inspect and copy their healthcare records (there may be exceptions)
  - Request an amendment of their healthcare records (however, the physician can refuse to make the requested amendment if the record is already complete)
  - Request and receive an accounting of the disclosures
  - File a complaint about the office's privacy practices with the Secretary of the Department of Health and Human Services
- Rios Family Medicine Clinic, PA is required by law to maintain the privacy of confidential medical information and to honor the terms of this Notice; and has the right to change its Notice of Privacy Practices, but will provide notice to the patients when it does so.

This notice is effective January, 22 2014

Rios Family Medicine Clinic, P.A.

OFFICE POLICIES

OFFICE HOURS

Monday	8:00am – 11:30 am, 1:00pm -4:30 pm
Tuesday	8:00am – 11:30 am, 1:00pm -4:30 pm
Wednesday	8:00am – 11:30 am, 1:00pm -4:30 pm
Thursday	8:00am – 11:30 am, 1:00pm -4:30 pm
Friday	8:00am – 2:00pm

Closed Saturdays, Sundays and major holidays

APPOINTMENTS

To schedule an appointment, call during office hours. To cancel an appointment, please call 24 hours prior to your appointment. If you are more than 15 minutes late for your appointment, you may need to wait or reschedule at a later date.

*** We do not accept patients with work related injuries nor injury due to a motor vehicle accident (MVA), We do not provide Chronic Longer Pain Management***

INSURANCE INFROMATION

On the day of your appointment you must have your insurance identification card and proper identification. If you do not have the required information with you or the information is not in our office at the time of your visit, you will be rescheduled to a later date.

REFERRAL AND AUTHORIZATIONS

If your insurance company requires a referral to see a specialist, we will follow the specific requirement to process that referral. This process is outlined by your insurance and take more than 24 hours to complete.