Welcome to our Practice!

PATIENT INFORMATION (PLEASE PRINT)

Full Name: _____ DOB: _____ Preferred Name: _____

Address: _____ City/State: _____ Zip: _____

Main Contact Phone: _____ (check one) ☐ Cell ☐ Home ☐ Work **Detailed message: YES / NO**

Alternate Contact: _____ (check one) ☐ Cell ☐ Home ☐ Work **Detailed message: YES / NO**

Sex: ☐ M ☐ F Email Address: _____ Race: _____

Language: ☐ English ☐ Spanish ☐ Other: _____ How did you hear about us? _____

Parent/Guardian Full Name: _____ Parent/Guardian Full Name: _____

PATIENT PREFERENCES

Preferred Pharmacy: (Name/Phone) _____

**EMERGENCY CONTACT

Name/Relationship: _____ Phone: _____

PRIMARY INSURANCE (All information is required if insurance card has not been provided, otherwise complete the ***bold* fields only)

Insurance Company: _____ Insurance Address: _____

Subscriber/Member ID: _____ Group #: _____

***Policy Holder/Guarantor Full Name*:** _____

Relationship to Patient: _____ ***Policy Holder/Guarantor DOB***: _____

**ADDITIONAL INSURANCE (If applicable)

Insurance Company: _____ Insurance Address: _____

Subscriber/Member ID: _____ Group #: _____

***Policy Holder/Guarantor Full Name*:** _____

Relationship to Patient: _____ ***Policy Holder/Guarantor DOB***: _____

**Authorization and Acknowledgement

I hereby state that the above information is true and correct to the best of my knowledge. I authorize the Cedar Park Physician Associates to release any information acquired in the course of my treatment to my insurance company, physicians, institutions or third party payers, as required for certain claims filed.

I authorize direct payment to be made to the Physician Associate practices for any and all medical or surgical services rendered. I understand if any services or changes are not covered by my insurance company, or if my eligibility cannot be verified prior to seeing the physician, I will be responsible for all charges incurred at the time of visit. By signing below, you understand and authorize that you may be billed for any unpaid services.

_____ _____ _____

Signature of Parent or Guardian | Printed Name | Date

Patient Name: _____ **DOB:** _____

Consent for Treatment

I hereby voluntarily consent for treatment. I permit the facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by facility personnel under the instructions, orders or direction of such physician(s).

If my physician deems necessary, I consent to the photographing or videotaping, including body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the facility.

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that he/she has read the forgoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent execute the above.

Signature of Parent or Guardian: _____ **Date:** _____

Relationship to Patient: _____

Patient Name: _____ **DOB:** _____

Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Cedar Park Physician Associates and its providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

(Circle one) YES NO

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form 3732-3732-PPSI-2061 (Rev. 09/2016) for review and a personal copy to keep will be provided upon request. If you have any questions about this notice, please contact the Facility Privacy Officer at (512)528-7000.

Signature of Parent or Guardian: _____ **Today's Date:** _____

Relationship to Patient: _____

Personal Health Information Release (PHI)

This release authorizes Cedar Park Physician Associates to discuss medical information regarding my care, lab results, imaging results, condition, treatment or diagnosis with the following:

☐ **Parent Name:** _____ **Ph Number:** _____ **Detailed message: YES / NO**

☐ **Parent Name:** _____ **Ph Number:** _____ **Detailed message: YES / NO**

☐ **Other *(Specify Name(s))*:** _____

Ph Number 1: _____ **Ph Number 2:** _____ **Detailed message: YES / NO**

How may we contact you with automated messaging?

Health Notifications	☐ Email	☐ Phone	☐ Text
Appointments	☐ Email	☐ Phone	
Announcements	☐ Email	☐ Phone	☐ Text
Billing	☐ Email	☐ Phone	☐ Text

The following people may pick up medication samples and/or prescriptions on my behalf:

☐ **Parent(s) (*Specify Name of Parent(s)*):** _____

☐ **Other *(Please specify)*:** _____

Signature of Parent/Guardian: _____ **Today's Date:** _____

Relationship to Patient: _____

Patient Name: _____ **DOB:** _____

OFFICE POLICIES

We strongly feel all patients deserve the very best medical care that we can provide. We have prepared this material to acquaint you with our office and financial policies. **Please initial all fields below.**

All Patients

_____ A $27.00 fee may be assessed for NO-SHOW appointments. Please call 24 hours prior to your appointment time if you are unable to make it.

_____ A $27.00 charge will be assessed on all **returned** checks.

_____ I understand that if I fail to pay amounts owed the clinic has the right to secure an outside collection agency and/or attorney to collect unpaid debt. I understand that any unpaid debt will be reported to credit-reporting agencies. I further understand that I will be responsible for any additional charges or fees incurred by securing the collection agency or attorney ~ including reasonable attorney's fees.

_____ I understand that I am responsible for updating my information (i.e., insurance, address, phone numbers) with the clinic in order for them to be able to contact me for future appointments, refunds, etc. I understand I can do this by contacting the office directly or on the Patient Portal.

_____ I understand that if I have a pending Medicaid application and do not provide a Medicaid ID number within 30 days, I will be considered as a Self-Pay patient and responsible for any incurred charges. If you provide proof of Medicaid coverage after 30 days, your account will be switched back to Medicaid. At that point we will bill Medicaid for all charges.

_____ I understand that there is a fee for copies of my medical records. I also understand that I may use the online patient portal to receive copies of part of my medical record instead.

_____ All co-pays are due when you check-in for your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

_____ In the case of **NO** insurance coverage, I understand that I am responsible for payment of services rendered to myself or my dependents **at the time of service** (unless prior arrangements have been made and approved through the office manager.)

_____ I understand that as a self-pay patient I will receive a 30% discount for medical services provided. I also understand that if I pay I pay in full at the time of service there will be an additional 20% off medical services. (This equals 46.6% off medical fees.) If I do not pay in full at the time I check out, the additional discount will not be given.

_____ I authorize any holder of medical or other information about myself to be released to the Social Security Administration and Health Care Financial Administration, or its intermediaries or carriers, any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withhold this information.) Regulations pertaining to Medicare assignments or benefits also apply.

WAIVER OF LIABILITY

There may be certain services that are not adequately covered by your insurance company. If the provider feels that the service is medically necessary and your insurance company denies payment, it will be your responsibility to pay for that service.

I have read and understand the payment policies listed above and agree to the terms provided.

Signature of Parent or Guardian: _____ **Date:** _____

Relationship to Patient: _____

Patient Name: _____ **DOB:** _____

ELECTRONIC PRESCRIBING NOTICE

What is electronic prescribing? Why does your provider E-Prescribe?
E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. Your provider participated in E-Prescribing because he/she cares about your health and well-being and E-Prescribing has multiple safety benefits.

How does E-Prescribing work?
Instead of writing out your prescription on a piece of paper, your provider enters it directly into the computer. Your prescription travels from your provider's computer to the pharmacy's computer. E-prescriptions are sent electronically through a private, secure and closed network, so your prescription information is not sent over the open Internet or as e-mail. Your E-Prescription arrives at the pharmacist's computer faster and may help to save you time. The E-Prescription can be sent to the pharmacy you choose. If you do not want your prescription sent electronically, or your pharmacy does not accept E-Prescriptions, your provider can print your prescriptions for you.

Privacy
The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared for treatment, payment, and healthcare operations. E-Prescriptions meet this requirement.

PATIENT CONSENT FOR E-PRESCRIBING

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Parent/Guardian Signature: _____ **Today's Date:** _____

Relationship to Patient: _____

Patient Name: _____ **DOB:** _____

PEDIATRIC HEALTH HISTORY

Are you seeing any Speciality Doctors?

_____ _____

_____ _____

Allergies to medication or food? If yes, list reaction.

☐ No known medication/food allergies

_____ _____

_____ _____

List current medications, including OTC and dosages (ex: 40mg 1 daily)

☐ NO MEDICATIONS

_____ _____

_____ _____

_____ _____

Date: **Vaccination History:** ☐ **See Records Attached**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History: ☐ **Adopted**

Medical conditions. (Ex: Diabetes, High Blood Pressure, Cancers) If deceased, list age.

☐ All First-Degree (Mom, Dad, Sibling) relatives have no current problems or disabilities.

Mother: _____ ☐ None

Father: _____ ☐ None

M Grandmother: _____ ☐ None

M Grandfather: _____ ☐ None

P Grandmother: _____ ☐ None

P Grandfather: _____ ☐ None

Sibling: _____ ☐ None

Date: **Surgical History:** ☐ **None**

_____ _____

_____ _____

_____ _____

Social History

Smoker? ☐ Yes ☐ N

Diet? (Please Circle)

Regular Vegetarian Vegan

Gluten Free Diabetic Other

Enter # of times per week:

Drink Caffeine? _____

Exercise? _____

Sporting Activities?

_____

Parents Marital Status?

(Please Circle)

Married Unmarried Divorced

Seperated Widowed

Number of Siblings? _____

Childcare? (Please circle)

None Relative Private Sitter

Daycare School

Answer Y/N to the following:

Animal Exposure? ____

Passive smoke exposure? ____

Smoke detectors in home? ____

Seat belt/Car Seat used? ____

Sunscreen used routinely? ____

Insect repellent used routinely? ____

Guns present in home? ____

Current School Grade? _____

School Name? _____

Patient Name: _____

DOB: _____

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.

All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*

	YES	NO
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

Patient/Family Member/Companion Signature	Date/Time ☐AM ☐PM
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time ☐AM ☐PM

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-512-528-7000 (TTY: 1-800-735-2989).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-512-528-7000 (TTY: 1-800-735-2989).

Nhà cung cấp này tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-512-528-7000 (TTY: 1-800-735-2989).

Signature	Date/Time ☐AM ☐PM
Witness	Date/Time ☐AM ☐PM

Patient Label