

PATIENT REGISTRATION FORM

**Today's Date:

Clinic Name:

PATIENT INFORMATION: (Please use full legal name, no nicknames)

*Last Name: _____ First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone # (____) _____ - _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex _____ Marital Status: _____ Drivers's Lic#: _____

*Employer Name and Address: _____

Work Phone #: (____) _____ - _____

E-mail Address: _____ Cell Phone #: (____) _____ - _____

Emergency Contact Name: _____ Emergency Phone #: (____) _____ - _____

Please tell us how you heard about us: _____ **REFERRED BY:** _____

GUARANTOR INFORMATION: (List person or Insured name responsible for bill – use full legal name, no nicknames)

*Relationship of Guarantor to Patient: Self _____ Spouse _____ Parent _____ Other _____

*Last Name: _____ First Name: _____ Middle Initial: _____

*Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ - _____ *Social Security #: _____

*Date of Birth: _____ Age: _____ *Sex: Female _____ Male _____

*Employer Name and Address: _____

Work Phone #: (____) _____ - _____

INSURANCE INFORMATION : (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

*Plan Name: _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy ID#: _____ *Group #: _____ Effective Date: _____

Claims Address & Phone: _____

SECONDARY INSURANCE:

*Plan Name: _____ *Insured's Name: _____

*Insured's Social Security #: _____ *Insured's Date of Birth: _____

*Policy ID#: _____ *Group #: _____ Effective Date: _____

Claims Address & Phone: _____

***REQUIRED FIELDS-PLEASE COMPLETE FOR BILLING. *ATTACH COPY OF INSURANCE CARDS.**

**TEXAS HEALTH MEDSYNERGIES
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS**

Patient Name: _____	Date of Birth: _____
Last Name	First Name

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Texas Health MedSynergies or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health MedSynergies is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Texas Health MedSynergies or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have read and been offered a copy of the Texas Health MedSynergies. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health MedSynergies. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Health MedSynergies representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Health MedSynergies to that effect in writing.

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-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my Texas Health MedSynergies physician or those under his/her supervision.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____
(if different from patient)

GUARANTOR NAME (Please Print): _____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last Name First Name

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the physician or the physicians' staff to know if my insurance will pay for any medical service I receive.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the medical services I receive.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible for all charges.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: _____
(please sign here - Patient or Responsible Party)

Date: _____

Responsible
Party Name: _____
(please print name of Responsibility Party if different from Patient)

DISCLOSURE REGARDING ANCILLARY SERVICES/RESEARCH PROGRAMS

Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging (MRI)	Bone Density Imaging
Mammography	Nuclear Imaging
Ultrasound	Laboratory
Computer Tomography (CT)	Durable Medical Equipment (DME)
Positron Emission Tomography (PET)	Echo Cardiograph
X-Ray	Sleep Therapy
Infusion Therapy	Audiology

Your physician may have an economic interest in or a business relationship with the company or person who provides the Ancillary Services. You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

Research Programs

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participating in a program your physician believes may be appropriate for you.

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

Printed Patient Name _____

Patient Signature _____

Date _____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released without your authorization to do so.

TODAY'S DATE: ___/___/___ DATE OF LAST PHYSICAL EXAM: ___/___/___

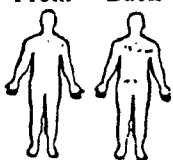
LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: ___/___/___

CHIEF COMPLAINT – What is the main reason for your visit today? (Describe your problem in detail)

HISTORY OF PRESENT ILLNESS

Please answer the following questions

<p>Location of the problem:</p> <p>Abdomen Back Leg</p> <p>Other: _____</p> <p>_____</p> <p>_____</p> <div style="text-align: center;">  </div> <p>On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.</p> <p style="text-align: center;">1 2 3 4 5 6 7 8 9 10</p> <p>When did you first notice the problem?</p> <p>2 days ago 2 weeks ago 1 month ago</p> <p>Other: _____</p> <p>Does anything help or make the problem worse?</p> <p>Moving around Standing up Lying on my side</p> <p>Other: _____</p> <p>Physician Use only (Comments/Notes)</p>	<p>How long does the problem last?</p> <p>30 minutes 1 hour It is always there</p> <p>Other: _____</p> <p>Is anything else occurring at the same time?</p> <p>Yes No If yes, please explain: _____</p> <p>_____</p> <p>Nausea Rash Headaches</p> <p>Other: _____</p> <p>Is the problem constant or variable?</p> <p>Dull then Sharp Very sharp then leaves Always there</p> <p>Other: _____</p> <p>Does the problem interfere with your normal functions?</p> <p>Yes No If yes, please explain: _____</p>						
<table style="margin-left: auto; margin-right: auto;"> <tr> <td># Answers</td> <td>Level of Service</td> </tr> <tr> <td>1 - 3</td> <td>1 or 2</td> </tr> <tr> <td>4+</td> <td>3 - 5</td> </tr> </table>		# Answers	Level of Service	1 - 3	1 or 2	4+	3 - 5
# Answers	Level of Service						
1 - 3	1 or 2						
4+	3 - 5						

PAST MEDICAL & SOCIAL HISTORY

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.)

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

Are you on any medications? Y N (If Yes, list all)

Are you on a special diet? Y N (If yes, please explain)

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Do you have drug allergies? Y N (If yes, please explain)

Physician Use Only: (Comments/Notes)

#Answers	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5