PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Office Practice/Clinic personnel at **River Hills Family Medicine** are hereby authorized to administer any medical diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstance.

Appointments

We block time in our schedule for your visit to the office. Please contact our office twenty-four hours in advance if you are unable to keep your scheduled appointment. **Failure to comply with this policy will result in a $50.00 missed appointment charge.** If you call to cancel or reschedule your appointment less than 24hours in advance you will be charged $50.00. This policy DOES apply to same day appointments.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by this Office Practice and Billing/Clinic and are accessible to office personnel. Office Practice Billing/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office Practice Billing/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to my health care provider who is or may become involved with my care. Texas law requires that this Office Practice/Clinic advises you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Herpes, Syphilis, Gonorrhea, and Human Immunodeficiency Virus Acquired Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize River Hills Family Medicine or its billing representatives to file insurance claims for Medical Services on my behalf and collect for services to which I am entitled. I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s) responsible for my care. I authorize and direct my insurance carriers including Medicare, Medicaid, private insurance or other Health plans to issue payment directly to **River Hills Family Medicine.**

I hereby authorize River Hills Family Medicine or its billing representatives to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

PRECERTIFICATION OF POLICY

I understand that this Office Practice/Clinic will assist with insurance pre-certification requirements, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment if we are not given the required information from you in advance of your treatment. Please notify us if you are required to have a referral from your Primary Care Provider.

FINANCIAL RESPONSIBILITY

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic. **All co-payments and deductibles are due at the time of service.**

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient, or duly authorized by the patient, to accept the terms of this document, and a copy has the same effect as an original.

_____	_____	_____	_____
Patient or Patient's Legal Representative	Relationship to Patient	Date Signed	Witness

New Patient Account Information

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

General Information

Print and fill out this form to register as a new patient with River Hills Family Medicine. All fields with an asterisk (*) are required Fields. We cannot register you as a patient without this information. Please fax the completed form to our office at (512) 346-7436.

Please call our office manager at 345-7436 with any questions.

Patient Information

Appointment Date: _____ Soc. Sec. No.:* _____

Address:* _____ Sex: (male or female) _____

City, State, Zip:* _____ Marital Status:* _____

Home Phone:* _____ Employment Status:* _____

Alternate Phone: _____ Preferred Phone No.: _____

Employer/School:* _____ Occupation: _____

Address: _____ E-mail:: _____

City, State, Zip: _____

Guarantor Information (person responsible for the bill)

First/Last Name:* _____ Soc. Sec. No.:* _____

Address:* _____ Date of Birth:* _____

City, State, Zip:* _____ Sex: (male or female) _____

Home Phone:* _____ Marital Status: _____

Alternate Phone: _____ Employment Status: _____

Employer/School: _____ Preferred Phone No.: _____

Address: _____ Occupation: _____

City, State, Zip: _____ Relation to Patient: _____

Subscriber Information (person that has the policy)

First/Last Name:* _____ Soc. Sec. No.:* _____

Address:* _____ Date of Birth:* _____

City, State, Zip:* _____ Sex: (male or female) _____

Home Phone:* _____ Marital Status: _____

Alternate Phone: _____ Employment Status: _____

Employer/School:* _____ Preferred Phone No.: _____

Address: _____ Occupation: _____

City, State, Zip: _____ Relation to Patient: _____

Please return completed form to the appropriate physician's office.

New Patient Account Information, cont'd.

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Primary Coverage

Subscriber:* _____ Plan Type: _____

Insurance Company:* _____ Policy ID Number: _____

Claims Address:* _____ Patient ID Number:* _____

City, State, Zip:* _____ Group Number:* _____

Phone:* _____ Office Visit Co-pay: _____

Patient's PCP:* _____ Verified by: _____

Effective Dates: _____

Secondary Coverage

Subscriber: _____ Plan Type: _____

Insurance Company: _____ Policy ID Number: _____

Claims Address: _____ Patient ID Number: _____

City, State, Zip: _____ Group Number: _____

Phone: _____ Office Visit Co-pay: _____

Patient's PCP: _____ Verified by: _____

Effective Dates: _____

Emergency Contact

First/Last Name:* _____ Home Phone:* _____

Address: _____ Alternate Phone: _____

City, State, Zip: _____ Relation to Patient:* _____

Patient Signature:_____ Date:_____

If someone other than the patient completed this form, please give name & relationship: _____
Name Relationship

Information Obtained by: _____ Date:_____

Account Created by:_____ Date:_____

Provider Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.

Authorization for Release and Disclosure of Protected Health Information

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Address:_____ City:_____ State:_____ Zip: _____

Soc. Sec. No.:_____ Telephone:_____

In accordance with state law and regulatory agency requirements, the health record is the property of River Hills Family Medicine. Specialty clinic charts are kept separate from your primary care chart and must be requested separately

I hereby authorize that my medical information be released: ☐ Pick-up ☐ Mail ☐ Fax (emergency only)

To: Name:_____ From: Name:_____

Address:_____ Address:_____

City/State/Zip:_____ City/State/Zip:_____

Telephone:_____ Telephone:_____

Please release the following information:

☐ Problem List	☐ X-Ray Reports	☐ Mental Health
☐ Progress Notes	☐ X-Ray Films	☐ Drug/Alcohol
☐ History and Physical Exam	☐ EKG Reports	☐ Lab Reports
☐ Immunizations	☐ Outside Records	☐ Medications
☐ HIV/AIDS Test	☐ Correspondence	☐ Previous Release of Information
☐ Other (specify)_____		☐ Date of Service_____

This information is necessary for the following purpose:

☐ Continued Patient Care ☐ Insurance ☐ Personal Use ☐ Attorney/Legal ☐ Other (specify)_____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoke, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or request copies of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I f I have questions about disclosure of my health information, I can contact the Office Manager at (512) 345-7436.

River Hills Family Medicine may receive direct or indirect remuneration as a result of disclosing this information due to_____

Patient Signature:_____ Date:_____

Witness Signature:_____ _____
Name Relationship

With respect to clients receiving chemical dependency services, this information has been disclosed to you from records protected by federal law (42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 USCA Sec. 290-dd(2).

Please return completed form to the appropriate physician's office.

River Hills
FAMILY MEDICINE

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Portability and Accountability Act-45 CFR Parts 160 and 164)

1. I hereby authorize all medical services sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named:

   _____

2. Authorization for release of PHI covering the period of health care (check one)
   a. _____ from (date) _____ to (date) _____ OR
   b. _____ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one):
   a. _____ my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse), OR
   b. _____ my complete health record ***with the exception of the following information*** (Check as appropriate):
      _____ Mental health records
      _____ Communicable diseases (including HIV and AIDS)
      _____ Alcohol/drug abuse treatment
      _____ Other (please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____

5. This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This Authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this Authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Authorization.

9. I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal law.

_____ _____
Signature of Patient Date