William J. Warren DPM, PA

PATIENT REGISTRATION FORM

Legal Name_____ Preferred Name_____

Date of Birth_____/_____/_____ S.S.#_____-_____-_____

Circle One: FEMALE MALE **Circle One:** Married Widowed Single Separated Divorced

Address _____ City _____

State _____ Zip Code _____ Preferred Language _____

ETHNICITY ◊ Hispanic or Latino ◊ NON-Hispanic or Latino **RACE** _____

Occupation_____ Patient Employer/School_____

Guarantor's Information

The person whose name the insurance is under, **only** if it is different from the patient.

Insured's Name_____ Date of Birth _____/_____/_____

S.S.# _____-_____-_____ Patient's Relation to Insured_____

Patient's Preferred Pharmacy _____ **Phone#** _____

E-mail Address: _____**REQUIRED**

Contact Phone Numbers

Home(____)_____ Cell(____)_____ Work(____)_____EXT_____

Preferred Contact - Circle One **home #** **cell#** **email**

Preferred Message – Circle One **text message** **voice-mail** **email**

****Please list Doctor, Patient, or Person's Name who referred you. _____

PRIVIA MEDICAL GROUP NORTH TEXAS

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. William J. Warren, with Privia Medical Group North Texas unless revoked by me in writing.

_____ _____/_____/_____

Patient / Legal Representative Signature Today's Date

Patient Name _____ Date of Birth ____/____/_____

INSURANCE INFORMATION

INSURANCE ASSIGNMENT AND RELEASE & MEDICARE AUTHORIZATION, NO SHOW Policy, and Insurance Forms

I certify that I have insurance coverage with the insurance company card(s) provided, including Medicare, Medicaid Services, and Medigap insurer, and assign directly to Dr. William J. Warren with Privia Medical Group North Texas, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges, whether paid by insurance. I understand that it is my responsibility to know my insurance benefits and whether the service(s) I am to receive are covered by my benefits. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named insurance company(ies), Medicare, Medicaid Services, and Medigap insurer, and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I also consent to having pictures taken to assist with any documentation for my health care, if needed.

All patient balances that are over 90 days old may be submitted to a collection agency with an up to 35% collection fee charge. Please keep your account in good standing; either by submitting a monthly payment or contacting the office manager to set up a monthly payment plan.

No Shows are defined as a scheduled appointment that was not cancelled or rescheduled by the patient or patient's representatives within 24 hours of the scheduled appointment. All **new** patients who **No Show** will be charged a reschedule fee. **No Show** appointments for established patients will be charged a $45 no show fee.

FMLA Paperwork / Employer Paperwork - Patient's that require forms to be filled out for their employers, such as, short term or long-term disability insurance documents pertaining to codes, dates seen, and their restrictions for work, etc. for their current issue will be charged a flat fee of $35 dollars for the initial paperwork. A flat fee of $10 dollars for any additional paperwork pertaining to the same claim. Each new issue will be a new case and the above-mentioned charges will begin again.

There will not be any recordings audio/video allowed in any of the patient rooms.

Please sign this form even if you do not have insurance, because your signature indicates that you read the other equally important information that has been provided.

_____ _____/_____/_____
Signature of Patient, Parent, Guardian, or Personal Representative Today's Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Are you under the care of a ***Pain Management Doctor*** ◊ yes ◊ no

Name_____ Phone#:(_____)_____

Are you under the care of a ***Cardiologist*** ◊ yes ◊ no

Name_____ Phone#:(_____)_____

Primary Care Physician _____ Phone #:(_____)_____

Patient Name _____ Date of Birth _____/_____/_____

MEDICAL HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following and the problems with an * asterisk, please use the space below to list the specifics of that problem.

AIDS/HIV	◊ yes	◊ no	High Blood Pressure	◊ yes	◊ no
Anemia	◊ yes	◊ no	Low Blood Pressure	◊ yes	◊ no
Angina	◊ yes	◊ no	Hepatitis A	◊ yes	◊ no
Arthritis	◊ yes	◊ no	Hepatitis B	◊ yes	◊ no
Asthma	◊ yes	◊ no	Hepatitis C	◊ yes	◊ no
Atrial Fibrillation	◊ yes	◊ no	Hyperthyroidism	◊ yes	◊ no
*Autoimmune Disorder	◊ yes	◊ no	Hypothyroidism	◊ yes	◊ no
*Back Problems	◊ yes	◊ no	Heart Attack	◊ yes	◊ no
*Bleeding Disorder	◊ yes	◊ no	*Kidney Problems	◊ yes	◊ no
*Cancer	◊ yes	◊ no	*Liver Disease	◊ yes	◊ no
Cerebrovascular Disease	◊ yes	◊ no	*Neurologic Disorder	◊ yes	◊ no
Charcot Marie Tooth	◊ yes	◊ no	Neuropathy	◊ yes	◊ no
CVA/Stroke	◊ yes	◊ no	Osteoarthritis	◊ yes	◊ no
COPD	◊ yes	◊ no	Osteoporosis	◊ yes	◊ no
Coronary Heart Disease	◊ yes	◊ no	Peripheral Artery Disease	◊ yes	◊ no
Crohn's Disease	◊ yes	◊ no	Pulmonary Embolism	◊ yes	◊ no
Chronic Renal Failure	◊ yes	◊ no	Psychiatric Care	◊ yes	◊ no
Depression	◊ yes	◊ no	Peptic Ulcer Disease	◊ yes	◊ no
Diverticulitis	◊ yes	◊ no	Radiation Treatment	◊ yes	◊ no
Diabetes Type 1	◊ yes	◊ no	*Respiratory Disease	◊ yes	◊ no
Diabetes Type 2	◊ yes	◊ no	Rheumatoid Arthritis	◊ yes	◊ no
Diabetes – Gestational	◊ yes	◊ no	Rheumatic Fever	◊ yes	◊ no
Insulin Dependent	◊ yes	◊ no	Seizure Disorder	◊ yes	◊ no
DVT	◊ yes	◊ no	Slow-Healing Wounds	◊ yes	◊ no
GI Bleed	◊ yes	◊ no	Stomach Ulcers	◊ yes	◊ no
Gerd	◊ yes	◊ no	Tuberculosis	◊ yes	◊ no
Gout	◊ yes	◊ no	Valvular Heart Disease	◊ yes	◊ no
Hemochromatosis	◊ yes	◊ no	Varicose Veins/Phlebitis	◊ yes	◊ no
Hyperlipidemia	◊ yes	◊ no	*Artificial Valves/Joints	◊ yes	◊ no

COVID-19 + ◊ yes ◊ no If YES, month/year _____/_____

Please be specific about the problems with * asterisks _____

_____

List any Surgery(ies) and Date they were performed _____

_____

_____

ALLERGIES

Please mark any allergies you have or have had. ◊ Adhesive / Tape ◊ Novocain

◊ Anticoagulant Therapy ◊ Penicillin ◊ Aspirin ◊ Sea foods ◊ Codeine

◊ Demerol ◊ Sulfa Drugs ◊ Iodine ◊ Other _____ ◊ No Known Drug Allergies

What reaction do you experience _____

Patient Name

Date of Birth

MEDICATIONS

Please list all prescriptions, over-the-counter medications, natural supplements, and vitamins, with the strength and how you take it.

Name of Medication, Vitamin, or Supplement	Strength (mg, mcg, etc.)	Directions(how often you take it)

Are you pregnant or do you think you may be pregnant? ◊ Yes ◊ No

SOCIAL HISTORY

CIRCLE the appropriate answer for the following. CIRCLE ANY that apply.

Do you **smoke, dip, chew or vape**? Yes Former Tobacco User NEVER USED

If you have quit, when? _____ If *YES*, Packs/Day_____Years _____

If Yes, Cans/Day_____Years_____

Do you drink? Yes No If YES, Beers/Day_____Years_____

If YES, Liquior/Day_____Years_____

Caffeine? Yes No If YES, Cups/Day_____Years_____

CIRCLE ANY that apply. **tea coffee energy drinks soda**

Do you use recreational drugs? Yes No If *YES*, What_____

How Much/Often?_____

Acknowledgement of Review of Notice of Privacy Practices & Financial Policy

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____/_____/_____

Signature of Patient / Responsible Party Birthdate of Patient

_____ _____/_____/_____

Printed Name of Patient / Responsible Party Date Signed

_____

Relationship of Responsible Party to Patient

Patient Financial Policy

Your understanding of our financial policies is an essential element of our practice and your care. If you have any questions, please discuss them with our office manager.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all insurance changes. In the event the office is not informed, you will be responsible for any charges denied.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We accept Visa, MasterCard, Discover, American Express, Care Credit, cash, and or check.
- There is a service fee of $35.00 for all returned checks. Once we have received a returned check you will no longer be able to write checks for payment of copays or balances.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, the balance will be your responsibility.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be 'Not Covered," or you do not have an authorization, you will be responsible for the charge.
- Surgical procedures will sometime require pre-payment. You will be informed in advance if your procedure requires pre-payment for co-insurance or deductible. In the event it applies to your procedure, payment will be due one week prior to surgery.
- Past due accounts are subject to collection proceedings. You agree to reimburse us the fees of any collection agency, which will be a percentage of the principal of up to 35% of the debt, and all costs, and expenses, including attorney's fees, we incur in such collection efforts, which will be added at the time the account is sent for collection. Please keep your account in good standing; if you have an outstanding balance, please make monthly payments on the account.
- **NO SHOWS** are defined as a scheduled appointment that was not cancelled or rescheduled by the patient within 24 hours of the scheduled appointment. All new patients who **No Show** will be charged a **$75 no show fee.** All established patients will be charged a **$45 no show fee.**

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate