AllCare Clinics
Family + Urgent Care

Patient Registration Form
(Please Print)

**PATIENT INFORMATION**

**PATIENT'S NAME**: _____
Last name First name Middle

**Birth Date:** _____/_____/_____ **Sex:** [ ] M [ ] F **Social Security** #: ____/___/____

Address: _____
(Number & Street) Apt # City (State/Zip)

Home#:_____ Cell#: _____ Email: _____

Employer: _____
Name Phone

**Marital Status:** [ ] Single[ ] Married [ ] Divorced [ ] Separated[ ] Widowed

**Employed Status:** [ ] Full time [ ] Not employed [ ] Self-employed [ ] Retired [ ] On active military duty

**Student Status:** [ ] Full time student [ ] Not a student [ ] Part time student

**Race:** [ ] African American [ ] American Indian or Alaska Native [ ] Asian [ ] Black [ ] Mexican American Indian [ ] White [ ] Decline to specify [ ] Other: _____

**Ethnicity:** [ ]Colombian [ ] Costa Rican [ ] Cuban [ ] Dominican [ ] Latin American [ ] Hispanic or Latino [ ] Non-Hispanic White [ ] Mexican [ ] Spaniard [ ] Salvadoran [ ] Decline to specify [ ] Other: _____

Preferred Pharmacy: _____ Phone #_____

**Emergency Contact**: _____ **Phone**: _____
Relationship: _____

How were you referred to our clinic? [ ] Web/online [ ] Yellow Pages [ ] Employer[ ] Doctor/Hospital [ ] Friend/Family [ ] Person/other_____

Do you have a living will? Yes/No Rx Eligibility Yes/No

**INSURANCE INFORMATION**
(Please give your insurance card and id to the receptionist.)

Primary Insurance: _____ Subscriber ID #_____Group#_____

Responsible Party Name: _____Relationship to Patient: _____DOB:____/___/_____

Address: _____
(Number & Street) Apt # City (State/Zip)

Secondary Insurance: _____ Subscriber ID #_____ Group#_____

Responsible Party Name: _____Relationship to Patient: _____DOB:___/___/__

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**HEALTH HISTORY AND CONSENT FORM**

**Reason for today's visit? _____**

**LIST all your MEDICATIONS: (Include birth control pill/injection, inhalers, Over the Counter(OTC), vitamins etc):_____**
**_____**

**MEDICAL HISTORY:**

**PREVIOUS/CHRONIC ILLNESSES: (Check appropriate boxes)**

| Have you had? | Yes | No | Have you had? | Yes | No | Have you had? | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Arthritis | | | Liver Disease | | | Sleep apnea | | |
| Anemia | | | Kidney Disease | | | Headaches | | |
| Allergies | | | Diabetes | | | STD: | | |
| Asthma | | | Thyroid | | | Cancer | | |
| High B/P | | | Stroke | | | Tuberculosis | | |
| Heart disease | | | Urinary stones | | | Pneumonia | | |
| Hepatitis | | | Eczema | | | COPD | | |

**DISABILITIES (including learning disability) & OTHER ILLNESSES not listed above: _____**
**_____**
**_____**

**LIST all your DRUG ALLERGIES and FOOD ALLERGIES:**
**_____**
**_____**

**PREVIOUS SURGERIES AND HOSPITALIZATIONS**
**(Month&Year):_____**
**_____**

Have you ever had a colonoscopy? **Yes/No**. If yes, what date? _____

**Males (50 and Over)** Last Prostate Exam: _____Abnormal Findings: _____

**FAMILY HISTORY: (Check appropriate boxes)**

| Family History | Yes | No | If yes, who? | Family History | Yes | No | If yes, who? |
|---|---|---|---|---|---|---|---|
| Arthritis | | | | Liver Disease | | | |
| Thyroid | | | | Stroke | | | |
| Diabetes | | | | Kidney Disease | | | |
| Asthma/COPD | | | | Cancer | | | |
| High B/P | | | | Urinary stones | | | |
| Heart disease | | | | Eczema | | | |
| Hepatitis | | | | Other: | | | |

Do you have any siblings? If yes, how many? Brothers: ____ Sisters: _____ Are they healthy? Yes/No
Do you have any children? If so, how many? Sons: _____ Daughters: _____ Are they healthy? Yes/No

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**SOCIAL HISTORY: (check appropriate boxes)**

| Are you a | Yes | No |
|---|---|---|
| **Current smoker** | | |
| **former smoker** | | |
| **nonsmoker** | | |
| **current every day smoker** | | |
| **smoker current status unknown** | | |
| **unknown if ever smoked** | | |
| **light tobacco smoker** | | |
| **heavy tobacco smoker** | | |
| **uses tobacco in other forms** | | |

If 'current smoker': How often do you smoke cigarettes**?** **Every day or Somedays, but not every day**

If 'current smoker': How many cigarettes a day do you smoke? **5 or less 6-10 11-20 21-30 31 or more**

If 'current smoker': How soon after you wake up do you smoke your first cigarette?
**within 5 minutes 6-30 minutes 31-60 minutes after 60 minutes**

If 'current smoker': Are you interested in quitting?
**Ready to quit Thinking about quitting Not ready to quit**

**SEXUAL HISTORY:**

Have you been sexually active in the past 12 months?
**Yes/No**

If so, with
**Women/Men/Both?**

Do you use protection: **Yes/No?**

If so, how often?
**All of time/ Most of the time/Half the time/Some of the time**

Have you ever had a Sexually transmitted disease: **Yes/ No?**

If yes circle one of the following?
***Chlamydia/GC/Syphilis/Herpes/HIV/Other***: _____

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Last Pap Smear: _____ Last mammogram: _____ LMP (last menstrual period) :_____

#Pregnancies: ___ #Miscarriages: ___ #Abortions: ___ Stillbirth:___ Natural Birth:____ C-section:_____

Did you have a drink containing alcohol in the past year? **YES/NO**

If 'Yes': How often did you have a drink containing alcohol in the past year?
**Never Monthly or less 2 to 4 times a month 2 to 3 times a week 4 or more times a week**

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
**1 or 2 drinks 3 or 4 drinks 5 or 6 drinks 7 to 9 drinks 10 or more drinks**

If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?
**Never Less than monthly Monthly Weekly Daily or almost daily**

Have you used drugs other than those for medical reasons in the past 12months?
**Yes/ No**
If so, circle the corresponding drugs:
**Marijuana/Cocaine/Heroin/PCP/Ketamine/Opiates/Ecstasy/LSD/Crack/ Methamphetamine**

Do you drink coffee?
**Yes/ No**

If yes: **1 or 2 cups 2 or 3 cups 3 or 4 cups 4 or more cups**

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**Notice of Privacy Practices**

No later than the first day if service delivery after April 14, 2003 compliance deadline, each patient will be provided with the Notice of Privacy Practices.

Except in emergency situation, AllCare Family and Urgent Care Clinics will make good faith efforts to obtain the patient's written acknowledgment of receipt of this notice (see attached form upon requested). If the acknowledgment cannot be obtained, the AllCare staff will document all efforts the acknowledgment and the reason(s) why it was not obtained.

In an emergency treatment situation, the notice will be provided as soon as reasonably practicable to do so after the emergency situation has ended. At the time, AllCare will make good faith effort to obtain written acknowledgment from the patient.

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

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 OR REPRESENTATIVE: _____

NAME OF PATIENT OR REPRESENTATIVE: _____

DESCRPITION OF PERSONAL REPRESENTATIVES AUTHORITY: _____

**General Medical Records Release and**
**Authorization for Use or disclosure of Protected Health Information**

Patient Name: _____Date of Birth: _____
Address: _____Phone:_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation for my health. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose/ release the full and complete protected medical information including the following *(*please check all applicable*):

[ ] All Records [ ] Laboratory/ Pathology Records [ ] X-ray/ Radiology Records
[ ] Billing Records [ ] Abstract/ Summary [ ] Pharmacy Records
[ ] Other (please describe specifically): _____

**Note:** *These records may contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted diseases, and you are hereby authorizing disclosure of this information.*

These records are requested for the services provided on the following date(s): _____

Patient Registration Form
(Please Print)

Please send the records listed above (use additional sheets if necessary):

_____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Address

_____ _____
Phone Fax

The information may be used/ disclosed for each of the following purposes:
[ ] At my request (only the patient can check this box) [ ] Employment purposes
[ ] For my health care [ ] Other: _____

This authorization shall expire no later than: ___/___/___or upon the following event_____
(Whichever is sooner) and may not be valid for greater than one year from the date of signature for Texas medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign

this document and authorize the use or disclosure of the protected health information and that there are no claims or orders pending, or in the effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print name and Relationship of Legally Authorized Representative Date

**FINANCIAL POLICY**

Allcare Family and Urgent Care Clinics, PA would like to welcome you to our office. The information below outlines how our practice operates. If you have any questions, please do not hesitate to ask. This is an agreement between AllCare Family and Urgent Care Clinics, PA, a Texas Professional Corporation, as creditor, and the Patient/Debtor named on this form.

Patient Registration Form
(Please Print)

In this agreement, the words "**you**", "**your**" and "**yours**" mean the Patient/Debtor. The word "**account**" Means the account that has been established in your name to which charges are made and payments credited. The words "**we**", "**us**", and "**our**" refer to AllCare Family and Urgent Care Clinics, PA.

**By executing this agreement, you are agreeing to pay for all the services received.**

**Monthly Statement**: If you have a balance on your account, we you will receive a call from our office. It will show separately the previous balance any new charges to the account, the finance charges, if any, and payments or credits applied to your account during the month.

Payment options **if you have no insurance**.

- You need to pay cash or credit card prior to the visit, to the day that treatment is rendered. **Please no checks**.

Payment options **if you have insurance**.

- You need to pay your deductible and any out of pocket portions at the time services are rendered by cash, or credit card.
- You need to pay all of treatment by cash, or credit card. Payment is due at time of service.

**Payment:** Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issue and is past due if not paid by the end of the month.

**Charges to Account**: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of services.

**Contracted Insurances:** If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, **you must pay that at the time of services**. It is the insurance company that makes the final determination of our eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and or pre-authorization may result in a lower payment from the insurance company. If your insurance fails to pay your claim, then you are responsible for the balance owed to us. In the event that you do not have your insurance information with you and the insurance denies the claim then you are responsible for the balance due.

**Non-contracted Insurance:** Insurance is a contract between you and your insurance company. We are NOT a party in this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and or pre-authorization may result in a lower payment from the insurance company.

**Collection fees:** A collection fee if up to $15.00 may be imposed on each account that is over thirty (**30**) days past due. We determine your account is past due by taking the balance owed thirty (**30**) days ago, then subtracting any payments or credits applied to the account during that time.

**Required Payments:** Any co-payments require by an insurance company **must be paid at the time of service.** Because this is an insurance requirement, we cannot bill you for these fees. Please note, you can be penalized by your insurance company by not paying this amount.

**Missed appointment fee:** Patients who do not show up on time for an appointment or cancel with less than a 24 hour notice will be charged a $25.00 fee. This fee must be paid before a new appointment is scheduled. **Patients with three (3) missed appointments may be asked to transfer their records to another doctor.**

Patient Registration Form
(Please Print)

**Forms**: Various forms and letters are often lengthy and may take extra time to be filled out. Please allow up to 7 business days for forms or letters to be completed by our office. There will be a $50.00 charge for letters or forms needing more than a signature.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs. It is the authorizing parent's responsibility to collect from the other parent.

**Transferring of Records:** You will need to request in writing to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

## SIGNATURE PAGE FINANCIAL POLICY

**Co-Signature:** If this financial policy if signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

**Effective Date:** Once you have signed this agreement acknowledgment a copy of the AllCare Family and Urgent Care Clinics Financial Policy was given to you, you agree to all of the terms and conditions contained therein and the agreement will be in full force and effect.

**Guarantor'sSignature:_____Date:_____**

**Co-Signature:_____Date:_____**

Patient Registration Form
(Please Print)

# ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

AllCare Family and Urgent Care Clinics, PA herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

**1.** Emails, text messages, and other forms of electronic communications (including Skype or FaceTime) may be utilized for communications bet*we*en the Private Practice and the Patient, and these communications may include references to the patient's Personal Health Information ("PHI"). The Patient acknowledges receipt and approval of Private Practice's Informed Consent to Use Patient Portal. The Patient authorizes the Private Practice to utilize the r*e*ferenced electronic communication methods despite acknowledging that such electronic communication methods lack any guaranty of privacy. The Private Practice will engage in good faith reasonable efforts to protect the Patient's privacy while engaging in such communication methods.

**2.** The Patient agrees to provide accurate mobile telephone number, email address and Skype contact information to the Priv*a*te Practice, and to immediately inform the Private Practice of any changes to the Patient's electronic contact information. The Patient authorizes the Private Practice to respond to all electronic communications that appear to be from Patient whether such communications arrive from the electronic contact information the Patient provides the Private Practice.

**3.** Under no circumstances shall the Patient utilize electronic com*m*unications to contact the Private Practice regarding an immediate emergency or time-sensitive situation: The Patient must call 9-1-1 an*d/*or immediately seek emergency medical attention.

**4.** The Private Practice values and appreciates the patient's privacy and takes commercially reasonable security *m*easures to protect the Patient's privacy. The Private Practice shall comply with HIPA*A/*HITECH with respect to all electronic communications.

**5.** The Patient acknowledges that electronic communications and related portable data communication and storage devices are prone to technical failures, are not 100% guaranteed to protect privacy, and can be hacked or the subject of theft or other events that ma*y* result in the loss of the Patient's information or data (including PHI). The Patient nevertheless authorizes the Private Practice to communicate with the Patient utilizing electronic communication solutions as requested and authorized by the patient. The Patient shall hold harmless the Private Practice and its owners, officers, directors, agents, and employees from and against all demands, claims, and damages to persons or property, *l*osses, and liabilities, including reasonable attorney's fe*e*s, arising out of, or caused by electronic communication (whether encrypted or not) losses or

disclosures caused by technical failures, privacy leaks, hacks, thefts, or other events not directly caused by the Private Practice.

**6.** The Private Practice will obtain the Patient's express written or electronic consent if the Private Practice is required or requested to *for*ward the patient's identifiable PHI to any third party, other than as authorized and specified in the Private Practice's Notice of Privac*y* Practices, or as authorized or mandated by applicable law. The Patient hereby consents to the communication of such information as necessary to coordinate care and achieve scheduling with the Patient and all parties responsible for providing or overseeing care. The Patient identifies the following individuals or entities as authorized to receive Patient PHI from the Private Practice in connection with authorized consulting, education, and all other aspects of supporting the Patient's care, and the Private Practice *m*ay share Patient PHI with such parties without additional written or electronic consent from the patient.

**7.** The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Private Practice terminating the use of electronic communication methods with the Patient and may result in the termination of the patient's agreement for Private Practice services.

**8.** The Patient hereby consents to engaging in electronic and after-hours communications referenced above with reference to and communicating the Patient's PHI, including communication with the parties identified in paragraph 6 above.

**9.** The Patient understands that all electronic communication methods and platforms, while convenient and useful in expediting communication, are prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorizes the Private Practice to communicate with the Patient regarding PHI via electronic communication methods and platforms referenced in this PHI Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Private Practice will otherwise endeavor to engage in reasonable privacy security eff*o*rts to achieve compliance with applicable laws regarding the confidentiality of the Patient's PHI and HIP*AA/*HITECH compliance. The Patient has received a Notice of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgement.

**10.** The Patient has the right to request from the Private Practice a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Private Practice shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information. However, the patient's Private Practice fees may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning, and

burning PHI to media and distributing the media with media costs charged to the Patient; and the Private Practice administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), the Private Practice's actual supply costs for such equipment may be charged to the Patient and the Patient agrees to pay the Private Practice such costs.

**11.** This PHI Agreement will remain in effect until either the Patient or the Private Practice provides written notice to the other party revoking this PHI Agreement or otherwise revoking consent to electronic communications between the parties. Such revocation will occur thirty (30) calendar days after written notice of such revocation. Revocation of this Agreement will

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to the Patient:

The Private Practice is required to provide you with a copy of our Notice of Privacy Practices, which states how the Private Practice may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment if you wish.

_____

I acknowledge that I have received a copy of the Private Practice's Notice of Privacy Practices.

Patient's name (please print): _____

Signature: _____

Date: _____

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FOR OFFICE USE ONLY The Private Practice made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from Patient, but it could not be obtained because:

☐ The Patient refused to sign.

☐ Due to an emergency, it was not possible to obtain an acknowledgment.

☐ The Private Practice was unable to communicate with the patient.

☐ Other: _____
_____
_____

preclude the Private Practice from providing treatment information in an electronic format other than as authorized or mandated by applicable law or by the patient. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Private Practice for all present and future purposes.

SIGNED BY: for each participating patient over the age of 21, a signature is required below.

PRIVATE PRACTICE

Signature: _____

Printed Name: _____

Title: _____

PATIENT:

Signature: _____

Printed Name: _____

Relationship to Patient: _____

Signature: _____

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