* Last Name: ______________________ *First Name: ______________________ Middle Initial ___
* Social Security #: ______________________ *DOB ______________________ *MRN: ______________
* Race: ______________ *Marital Status: ______________________ * Language: ______________
* Address ______________________________________________ * Zip Code: ______________
* Email Address ______________________________________________________________

**Place of Service** ______________________________________________________________

## Patient Privacy Directive

*In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.*

- Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

______________________ ______________________
______________________ ______________________

- Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or test results:

______________________ ______________________
______________________ ______________________

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

______________________ ______________________
______________________ ______________________

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your treatments and/or test results:

______________________ ______________________
______________________ ______________________

- Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

______________________ ______________________
______________________ ______________________

- Please provide an email address that his office may communicate health information to you with:

______________________

Please provide a cell phone number that we may text health information to:

______________________

- Please provide us with the name and number of your emergency contact:

______________________ ______________________

You must inform us **in writing** of any changes in your directives.

**I acknowledge that everything above is accurate.**

______________________ ______________________ ____________
*Signature* *Printed Name* *Date*

**I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"**

______________________ ______________________ ____________
*Signature* *Printed Name* *Date*

______________________ ______________________
*Relationship if Patient Representative* *Physician Office Representative*

## 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:** ______________________________ **Date:** ________________
*(please sign here – Patient or Responsible Party)*

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

# TEXAS HEALTH PHYSICIANS GROUP
# 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 Physicians Group 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 Physicians Group 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 Physicians Group 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 Physicians Group. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health Physicians Group. 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 Physicians Group 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 Physicians Group 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 Physicians Group physician or those under his/her supervision.

PATIENT SIGNATURE:______________________________ DATE:______________

GUARANTOR SIGNATURE:____________________________ DATE:______________
(if different from patient)

GUARANTOR NAME (Please Print):

**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: ______________________________ Social Security #____________________

Street Address: ____________________________________________ ______ Zip Code __________

* Employer Name: ____________________________________________________________

**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 #: ____________________ * Eff Date: ________

Claims Address & Phone: ____________________________________________________

**SECONDARY INSURANCE**

Plan Name: __________________________ * Insured's Name: ________________________

* Insured's Social Security #: ________________ * Insured's Date of Birth: __________________

* Policy / ID #: ____________________ * Group #: ____________________ * Eff Date: ________

Claims Address & Phone: ____________________________________________________

*** REQUIRED FILEDS – PLEASE COMPLETE FOR BILLING ***

*** ATTACH COPY OF INSURANCE CARDS ***