Patient Registration Form – Adults

Patient Information

Patient's Last Name First Middle Initial		Date of Birth	Sex ☐ Male ☐ Female
Race Hispanic ☐ White ☐ Black/African American ☐ Asian☐ American Indian/Alaska Native☐ Native Hawaiian or Pacific Islander☐ Decline to answer☐		Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer	
Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed	Primary Language	Social Security Number	
Patient's Mailing Address		City	State / Zip
Home Phone ☐ check if primary ( )	Cell Phone ☐ check if primary ( )	E-mail address:	
Day/Work Phone ☐ check if primary ( )	Alternate Phone ( )	Mother's Maiden Name	
Patient Employer Name	Employer Address	City	State / Zip
Employer Phone ( )	Patient Occupation	Employment Status: ☐ Not Employed ☐ Full Time ☐ Part Time ☐ Student ☐ Self-Employed ☐ Retired and Date: _____	
Full Name of Emergency Contact	Relationship	Home Phone ( )	Cell Phone ( )

Guarantor or person responsible for bill

Patient's Last Name First Middle Initial			Date of Birth	Relationship to Patient	
Street Address Apt. No.				SSN	
City / State	Zip	Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Employer Name	Employer Address		City	State / Zip	
Employer Phone ( )	Occupation		Employment Status: ☐ Full Time ☐ Part Time ☐ Retired and Date: _____		

Insurance Information

Primary Insurance Company	Subscriber's Full Name	Subscriber's Date of Birth:	
Subscriber ID Number	Group Number	Relation to Insured	
Secondary Insurance Company	Group Number	Relation to Insured	
Subscriber ID Number	Subscriber's Full Name	Subscriber's Date of Birth:	

Pharmacy Information

Local Pharmacy	Pharmacy Phone number
Pharmacy Address, City, State, Zip	Mail Order Pharmacy Name

Acknowledgement: By signing below I signify that the information I have provided is accurate to the best of my knowledge. This signature also signifies my general consent for treatment to Valley House Calls, PLLC to provide any and all medical treatment to myself or my dependent.

Signature: **X** _____ Date: _____

Acknowledgements: By signing below you signify acknowledgement of the following:

- You have received our "Late Cancellation and No-Show Policy" in this packet and it explains the $50 charge for each instance.
- You have received the *Disclosure Form for Sharing and Communication* in this packet and it explains our participation in an Accountable Care Organization (ACO) and Health Information Exchange (HIE) and additional ways we may utilize your information to better serve you.

Signature: **X** _____ Date: _____

ASSIGNMENT OF BENEFITS FORM

I hereby assign and convey Valley House Calls, PLLC, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services. I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Valley House Calls, PLLC for any equipment or services (i.e., provider visits, treatment, therapy, and/or medications) rendered or provided to me by the organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Centers for Medicare and Medicaid Services (CMS) my insurance carrier or other medical entity. A copy of this authorization will be sent to CMS, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand and agree:

- That I am financially responsible to the organization for all charges regardless of any applicable insurance or benefit.
- It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim.
- I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Valley House Calls, PLLC any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from Valley House Calls, PLLC or its attorneys in order to claim such medical benefits.

I understand that by signing this form I am accepting financial responsibility as explained above for all payments on the services I receive.

_____	**X**_____	_____
Patient/Beneficiary Name *(Please print)*	Signature	Date

MEDI-GAP/ MEDICARE SUPPLEMENTAL INSURANCE LIFETIME ASSIGNMENT OF BENEFITS:

I, the undersigned, have Medi-Gap Insurance coverage and assign directly to:

Valley House Calls, PLLC , all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until revoked by me in writing.

X_____	_____	_____
Signature of Beneficiary	Insurance ID Number	Date

DISCLOSURE FORM FOR SHARING AND COMMUNICATION

We may utilize a **Patient Portal** and/or an **Automated Appointment Reminder** and **Messaging** system to allow us to better serve you. (ex. appointment reminders via phone and text, online appointment requests, communicate with office via email, online access to your medical information) By providing your cell phone number and email address we will automatically enroll you in this system(s) if they are available.

Disease and Immunization and Texas Immunization (Immutrac) Registries are a computer based tracking systems developed to assist medical providers and other approved agencies to track and review medical information for individuals, to assess needs and avoid redundant immunizations, and control disease outbreaks.

Medication History Authority: Our Electronic Medical Records (EMR) program can automatically import your medication history from third party sources (i.e. pharmacies). In order to transfer your current and past medications to our system we must have your authority. By signing below I hereby certify Valley house Calls, PLLC to transfer my Medication History.

I have been made aware of the above disclosure. _____ Initials

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of information about how we may use and disclose your protected health information. We encourage you to read it in full.

Health Information Exchange (HIE) - we may make your individual health information available to a sponsored Health Information Exchange (HIE) and to a regional and/or National Health Information Exchange.

Accountable Care Organizations (ACO) – we will be sharing your health information with our Accountable Care Organization (ACO).

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy on our website **wwww.valleyhousecalls.com** If you have any questions about our *Notice of Privacy Practices* please contact our Privacy Officer at (956) 276-4560

I acknowledge receipt of the *Notice of Privacy Practices* of Valley House Calls, PLLC.

I have been made aware of the above disclosures and understand that complete details are available in the Notice of Privacy Practices I was given. _____ Initials

_____ _____

Name of Patient/Legal Representative *(please print)* Date

X_____ _____

Signature of Patient/Legal Representative If Legal Representative, please give relationship

Patient did not sign Notice of Privacy Practices Acknowledgement reason: ☐ Refused ☐ Unable to sign *(specify)*_____

Who is responsible for the bill?

Healthcare and insurance have changed since the beginning of the Affordable Care Act. We are finding that insurance companies that have paid for virtually all laboratory testing and in office procedures in the past are now being much more selective about the type of tests and procedures that they are paying for. We are also finding that many more patients have high deductible insurance plans and are therefore responsible for larger portions of their bills.

Please understand that we cannot know which tests and procedures are covered by your individual insurance. We also cannot be responsible when you and/or your employer choose a high deductible insurance plan. Our interest is in providing you with the very best medical care taking advantage of all the recent technologies and testing that help to insure your good health.

We try, to the extent possible, to inform you when we are aware that a particular test or procedure may be expensive. Very often we are unaware of the actual costs for a given test or procedure. We know that hormone tests, for example, tend to be expensive and therefore we attempt to inform you of this. As recommended call your insurance carrier prior to laboratory testing and ask if your insurance carrier requires a preferred lab and we will try to make reasonable accommodations.

We use Quest Diagnostics and Community Reference Lab for our lab testing. If they are not your preferred laboratory we will gladly give you a lab order for your preferred laboratory.

The bottom line answer to the question asked above – is that you are responsible for the bill for tests or procedures that are ordered on your behalf. It is your responsibility to know when you have a high deductible insurance policy. When you know that you have a high deductible policy you should ask what the price of tests or procedures that are being ordered you may cost. Very often, it is more economical to pay the self-pay rate (as if you don't have insurance) than it is to send the bill to insurance and then pay the full rate when the insurance company denies payment because of your deductible or copay.

Be assured, our interest is solely with providing you with modern, up to date, exceptional care. We are as frustrated by the changes in healthcare policy that lead to these issues as you are. We are on the same side. Please do not attempt to hold us responsible for issues that arise relating to the details of the insurance policy you have. We do not have control over what you and perhaps your employer have chosen for insurance coverage. As always, we appreciate when you choose us to provide you with your healthcare needs.

☐ I acknowledge that I have read the above statement.

_____

Signature Date

VHC Office Policies & Procedures

Co-Payment & Co-Insurance

Co-pays & Co-insurances are due at the time of service. Our office does not bill you for Co-pays & Co-insurances. We accept cash, and credit cards. We do not accept checks.

Insurance Cards

We require your insurance card for all visits. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number, please inform the office. If you have not provided our office with the correct insurance information, you will be responsible for any balance due. We are unable to re-submit insurance claims.

Self-Pay Patients

If you do not have insurance, your balance is due at the time of your office visit. Our office accepts cash, Visa, Mastercard, American Express and Discover.

Not Showing For Your Scheduled Appointment

We ask for a 24-hour notice when canceling an appointment. No showing for an appointment will result in a $50.00 fee which is not covered by insurance. Frequent no-shows or cancellations will result in being discharged from the practice.

Dismissal

We reserve the right to dismiss patients from Valley House Calls after three missed appointments or No Shows in 12 months.

Minors

A parent or guardian must accompany all patients under the age of 18. Any family members over the age of 18 accompanying minor must have prior arrangements made with the office.

Laboratory Services

Quest Diagnostics & Community Reference Lab provides services. Coverage of labs will depend on your plan and whether our drawing labs are in-network with your insurance plan. Having insurance is not a guarantee of coverage and all fees will be the responsibility of the patient. Please contact your insurance provider for your in-network lab provider.

Texas Health Steps Visit

All TMHP annual visits must be scheduled. All Texas Health Step visits require a current and updated vaccine record.

Motor Vehicle Accidents

We will not see patients involved in a recent motor vehicle accident without an emergency visit.

Paperwork To Be Filled Out by The Medical Provider

To fill and complete medical forms such as FMLA, health screenings, and short-term disability. An appointment may be required to complete forms. Please check with the staff to see if your form will need an office visit. We will schedule an appointment if necessary. FMLA will be a minimum process time of 14 business days.

Forms Fees

Our office charges a fee for the completion of any form which requires medical information and a medical provider's signature. All forms require pre-payment. If the medical provider feels it is necessary to obtain more information from the patient to complete the form, the patient may be required to make an appointment. If this is the case, we will contact you.

Workman's Compensation & DOT Physicals

We do not handle workman's compensation visits or provide any DOT Physicals

Diagnosis Codes

Our office cannot recode an office visit because your insurance does not cover specific visits. It is the patient's responsibility to know what your insurance plan covers. Physicals, shots, and procedures are a few examples of what some insurance companies may not include. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days.

Uncooperative Patients

Our medical provider is not required to continue treatment of an uncooperative patient. Patients who refuse to follow treatment advice and/or presents difficulties in the medical provider-patient relationship. Our goal is to try to accommodate all of our patient' needs. Demanding and abusive language does not help us achieve that goal. Dismissal from our practice for non-compliance could be deemed necessary.

Signing below you acknowledge and understand all the statements above.

_____

Patient Name | Patient or Guardian Signature | Date