PATIENT REGISTRATION

Name_______________________________________Preferred/Nickname___________________________

Gender (must match insurance card)____DOB____________SSN____________________Age____

E-mail____

This practice may send you email notification through **Patient Fusion,** a secure messaging portal regarding your appointment, bill, lab results, other health information. By providing your email address you consent to being contacted via the patient portal.

Address________________________________Apt________City___________State______Zip__________

Ethnicity/Race__________Occupation______________________Phone ________________________

This practice may send you text notification through **Patient Fusion,** a secure messaging portal regarding your appointment. By providing your initials you consent to being contacted via text.(_______Initial)

IN CASE OF EMERGENCY

Name__________________________Relationship______________Phone_________________________

BILLING INFORMATION

Primary Insurance Carrier_____________________ Are you the Subscriber? Yes/No

Subscriber Name_______________________________ Relationship_____________DOB____________

Secondary Insurance Carrier___________________ Are you the Subscriber? Yes/No

Subscriber Name________________________________ Relationship_____________DOB___________

PHARMACY Nau's/Lamar Plaza/Tarrytown/People's/CVS/Walgreens/other _________________________

Pharmacy ZIP Code_____________

Whom may we thank for the kind referral? WORD OF MOUTH / ANOTHER PATIENT / FAMILY

MEMBER / GOOGLE / INSURANCE COMPANY DATABASE / OTHER:_______________________

______________________________________ ______________________

Patient Signature Today's Date

We are also your urgent care/walk-in clinic; open every day but Sunday!

Patient Name:____**DOB**__________________

Do you have a Primary Care Physician? Yes No
Would you like us to be your Primary Care Clinic? Yes No

SOCIAL HISTORY
Current Smoker? Yes/No Former Smoker? Yes/No Chewing Tobacco? Yes/No
Do you drink Alcohol? Yes No Is it a problem: Yes No
Do you Exercise? Yes No If **Yes** what type?________________How Often?______________

Hobbies____
Number of Children______Years of birth_____________________________________

SURGICAL HISTORY NONE
List Surgeries and/or hospitalization you have had with year

____ ____________________________________
____ ____________________________________
____ ____________________________________

ONGOING MEDICAL ISSUES NONE

____ ____________________________________
____ ____________________________________
____ ____________________________________

DO YOU HAVE SEASONAL, ENVIRONMENTAL OR FOOD ALLERGIES? NONE
__ MA provide allergy testing information if applicable ____________________________

____ ____________________________________
____ ____________________________________

MEDICATION ALLERGIES NONE
List any allergies to medication and any type of reaction.

____ ____________________________________
____ ____________________________________
____ ____________________________________

FAMILY AND PERSONAL HISTORY
Specify if you or a blood-relative have or had any of the following

Heart Attack____________ Diabetes____________ High Cholesterol ____________
Heart Disease____________ High Blood Pressure____________ TB____________
Stroke______________ Cancer______________ Pancreatic Cancer ____________
Breast Cancer ______________________________ Lung Cancer ____________ Colon Cancer
______________ Glaucoma____________ other _________________________

Patient Name______________________________ Date of Birth_________ Today's date:_____________

Privacy Practices and Health Updates

HIPPA PRIVACY PRACTICES: I have read and understand laminated HIPPA form at front desk INITIAL:__________

[illegible]: this is giving permission for us to share healthcare and/or billing information WITH A FAMILY MEMBER OR OTHER PERSONS. Add the family member/other persons name to the line provided and circle healthcare info or billing or circle both:

Name____________________________________Relationship_____________________
Circle one or both: Healthcare information Billing information

Name____________________________________Relationship_____________________
Circle one or both: Healthcare information Billing information

______ (check for yes) There is no one I give permission to share healthcare information with (this may be updated at any time)

PREVENTIVE CARE: year of last: Physical___________Colonoscopy________prostate exam______

Prostate Blood Test (PSA)________Testosterone level_______ Date last menstrual period________

Age of first period_____Cycles irregular / regular What form of birth control do you use?__________________

Are you satisfied with your current form of birth control? Yes/no

Bone Density Test (year of most recent)_______Date last Mammogram______Date of your latest pap smear: month___ year____History abnormal pap or mammogram? Yes / no (circle one) if yes, details: ___________________________

IMMUNIZATIONS: Year latest Flu____ [illegible] Pneumonia____ DTAP (tetanus)____ Hep A/B____ Guardasil___ Shingles________

Were you born between 1946 - 1964? Yes / No [illegible] order testing if Quest order HCV Ab reflex to HCV RNA PCR quant

Medication/Vitamin/Supplement Name	Dosage	Strength

CONSENT TO TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and any recommended medical or diagnostic procedure after being advised of risks and hazards involved. **It is the patient's responsibility to pay co-pay or deductible amount at time of visit.** This is information so you may give or withhold your consent to the visit.

This form has been fully explained to me. I have read it or had it read to me and I understand its contents.

____

Name of PATIENT (Printed)   DOB   Date

____

Signature of PATIENT (OTHER LEGALLY RESPONSIBLE PERSON)   relation to patient

DOWNTOWN DOCTOR FINANCIAL POLICY

Thank you for choosing Downtown Doctor for your health care needs. We are committed to providing you with quality care The purpose of this financial policy is to better inform and advise you of your responsibility for services rendered. Please read it, ask us any questions you may have, and sign in the space provided.

- **INSURANCE:** The clinic participates in most insurance plans, including Medicare. Claims will be submitted for your visits to insurance plans with which we are in-network. Payment in-full is expected at the time of service, including co-pays and deductibles. Knowing your insurance costs and coverages is the responsibility of the patient.
- **AFTER HOURS' FEE:** Appointments before 8 am or after 5 pm on weekdays and appointments on Saturdays will be billed to insurance as an extended hours' fee. If insurance applies this fee to patient responsibility, the patient is responsible for the extended hours' fee of $50.
- **CANCELATION/NO CALL NO SHOWS:** If patient is late, cancels appointment less than 48 business hours prior to scheduled appointment, or does not show for an appointment. the patient will be responsible for a fee of $75 for an office visit and $120 for a missed procedure.
- **SIGNED LETTERS AND FORMS FEE:** A fee of $165 will be charged for special letters and forms signed and/or notarized. This fee does not apply to disability forms. Insurance claims will not be submitted by the clinic.
- **PROOF OF IDENTITY AND INSURANCE:** All patients must provide proof of ID and valid insurance card prior to being seen by a doctor or physician assistant.
- **CLAIMS SUBMISSION:** The clinic will submit your claim, but does not guarantee acceptance of claim Your insurance company may need you to supply additional information to them directly. Any claims not covered by your insurance are considered patient responsibility and will be billed accordingly.
- **CHANGES TO YOUR INFORMATION:** Notify clinic of address, phone, or insurance changes prior to next appointment to maximize your benefits.
- **NONPAYMENT:** After the first statement is sent and is not paid within 30 days, the second statement will have a late charge fee of $5 added to the balance. If there is a balance more than 90 days old, it will be sent to collections with an additional 40% added to balance.
- **RETURNED CHECKS:** The clinic charges $75 fee for a returned check.
- **Credit Card Payments:** We take all major credit cards as well has HSA/FSA/Care Credit payments. Please make sure that you are using the correct card. If the office needs to refund/void due to wrong card used it would be a $38 fee.

- **BILLING INFORMATION:** If patient has questions about their account, contact our billing department at 512.391.9400. Bills can be paid through the clinic portal: **www.PayStatementOnline.com**, or mail payment to Downtown Doctor at 1611 W 5th Street, Ste 180, Austin TX 78703.

I have read and understand the Financial payment policy and agree to abide by its guidelines:

Today's Date______________ Signature________________________________Date of Birth____________

CONTROLLED SUBSTANCE AGREEMENT

I, (print name)________________________________ Date of Birth ____________ understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following.

- **MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT** If I am currently involved in mental health therapy, or if I enter such therapy per instruction of Doctor/PA/NP, I authorize my mental health practitioner to exchange unrestricted information regarding pain (complete shared medical information in Office Policies and Procedures)
- **USE OF MEDICATION** I will take all medications as prescribed. I will not make any change in dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medication must all be obtained from the same pharmacy each time (exceptions must be approved by Doctor/PA/NP). I will abstain from alcohol use. I will not obtain the controlled substance/s which I receive here from another Medical Facility
- **DRUG SCREENING** I will participate in drug screening as a part of my treatment plan. I understand that drug screening may be conducted at any of my office visits or I may be called to come in to provide a urine sample. Screening may include urinalysis, blood testing and/or pill counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services.
- **ILLEGAL AND NON-PRESCRIBED DRUG USE.** I understand that the use of any controlled medication not prescribed by the practice may result in termination of care. I understand the Downtown Doctor cooperates with city, state & federal law enforcement agencies as well as the Texas board of Pharmacy. I understand that the use of any illegal substance, may result in termination of care.
- **LOST OR STOLEN MEDICATIONS** will not be replaced.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL MY QUESTIONS ABOUT THE TERMS OF THE AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THE AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.

Signature ________________________________ Today's Date____________

Credit Card Authorization Form

By filling out this form, you are authorizing **Downtown Doctor** to charge *your credit card* for scheduled appointments. You are also confirming that you are aware of our office policies. The **information** contained in this document is **strictly confidential** and is intended for the use of **Downtown Doctor** only.

- $ 75 for cancelled appointments less than 48 business hours in advance
- $ 75 No Call / No Shows / Late for appointment will be considered missed
- $ 120 Missed Procedure appointment
- Other charges as detailed in Downtown Doctor financial policy

Name on the Card: ________________________________

Type of Card: Visa ___ MC ___ AmEx ___ Discover ___ Other ___

Card number__________________________________

Expiration Date _______ Security Code _______________

By signing this form, you authorize Downtown Doctor to charge your card for the amount listed above.

Printed Name:______________________________________

Signed:______________________________ Date: ___________