PATIENT REGISTRATION

Name (must match insurance card) ______________________Preferred name/pronoun/s_____________

Gender (must match insurance card) ____DOB____________SSN___________________Age____

E-mail____

Address__________________________________Apt________City___________State______Zip__________

Ethnicity/Race___________Occupation_______________________Phone _________________________

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:________________________
Reason for Visit today:____

CONSENT TO TREATMENT

I have asked for and consent to medical treatment by Downtown Doctor Providers (Doctors/PAs/NPs and others under Dr. Freeman). I have been advised of some risks and hazards of medical care and know no list could be inclusive.

____
Name of PATIENT (Printed) DOB Date

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

____ _______________________
Patient Signature Today's Date

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 and review allergy packet, schedule allergy testing _________________________________

____ ____
____ ____

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 _____________hormone receptor positive?_____________ Lung Cancer ________________
Colon Cancer ___________________ Glaucoma______________ other ______________________________

Patient Name______________________________ Date of Birth_________ Today's date:______________

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

This section MUST be completed: 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

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

______ (Initials) My practice has documented that this Patient has provided their prior express consent to receive automated text and voice messages at the phone number(s) above through our system Practice Fusion.

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____ if not recent MA order and provide Pneumonia____ DTAP (tetanus)____ Hep A/B____ Guardasil___ Shingles________

Were you born between 1946 - 1964? Yes / No if yes, MA order testing if Quest order HCV Ab reflex to HCV RNA PCR quant

Medication/Vitamin/Supplement Name	Dosage	Strength

DOWNTOWN DOCTOR FINANCIAL POLICY

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

- We participate in most insurance plans, including Medicare. We will submit clams for your visits to insurance with which we are in-network. Payment is expected at the time of service, including and not limited to co-pays deductibles, convenience hour fee. You are responsible for knowing your insurance costs and coverages.
- Convenient HOURS' FEE: Before 8 am, on or after 5 pm on weekdays, and weekend appointments are billed to United Healthcare (UHC). If your insurance is not UHC, you will pay $38 at the time of visit for this convenience.
- Late to appt/cancels appointment < 48 business hr prior to scheduled appt/no show for appt, patient responsible fee $75 for office visit / $120 for missed procedure.
- $165 for special letter or form we create and sign and/or have notarized. This fee does not apply to disability forms.These are not covered by insurance, we will not submit a claim for them
- Photo ID + valid insurance card prior to being seen
- We will claims to your insurance company with no guarantee of acceptance or coverage. Your insurance company may need you to supply additional information to them. Charges not covered by your insurance are your responsibility.
- Notify clinic of address, phone, or insurance prior to your next visit. Delay may incur charges related to returned mail or unpaid insurance claims
- NONPAYMENT: If 1st statement not paid within 30 days your balance will increase by $5. Balances > 90 days go to collections + 40% collections' fee
- RETURNED CHECKS: The clinic charges $75 fee for a returned check.
- We accept credit cards/HSA/FSA/Care Credit. $ 38 processing fee for having to rerun any card
- Pay bill online: **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 it

Today's Date______________ Signature__________________________________Date of Birth_____________

Credit Card Authorization

- $ 75 for cancelled appointments < 48 business hours in advance /No Show scheduled appointment / Late for appointment
- $ 120 see #1 but for scheduled procedure appointment
- Other charges as detailed in Downtown Doctor financial policy

I authorize use of my card for any outstanding balance or fee. The information contained in this document is strictly confidential, internal use only

Name on Card: ___________________________________Type of Card: Visa / MC / AmEx / Other

card number_________________________exp_________security code ________

Signature:_________________________ today's date: ______________

CONTROLLED SUBSTANCE AGREEMENT

I, (print name)______________________________ Date of Birth ____________

My provider is prescribing a controlled substance, I agree to and will comply with:

- 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)
- 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
- 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.
- 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.
- Allow 48 business hours for any controlled substance to be sent to your pharmacy

I understand and agree to these terms. All of my questions have been answered. Failure to comply to any term may result in immediate termination from this clinic.

Signature ______________________________ Today's Date____________