

Segal Family Medicine Center –Patient Registration Form

(Please Print)

DATE:

Primary Physician: <input type="radio"/> Irwin Segal <input type="radio"/> Aaron Segal <input type="radio"/> Stephanie Segal

PATIENT INFORMATION				
Patient's last name:	First name:	Middle name:		
Mailing Address:	City:	State	Zip:	
Email address: <i>(We will not share this with any other entities. We will not send any confidential information via email)</i>				
Home phone:	Cell phone:	Work phone:		
Patient DOB	Age:	Sex:	Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed <input type="checkbox"/> other	
Social Security No.	Employer Name:			
Employment Status				

IN CASE OF EMERGENCY				
Name of emergency contact person:	Relationship to patient	Home phone:	Work or Cell phone: () -	
Mailing Address:	City:	State	Zip:	

RESPONSIBLE PARTY (GUARANTOR)				
Guarantor's last name:	First name:	Middle name:		
Mailing Address: (if different from patient)	City:	State	Zip:	
Guarantor's phone number: () -	Relationship to patient:	Guarantor's DOB	Guarantor's Social Security No.: - -	

INSURANCE INFORMATION		
Name of primary insurance:	Policy subscriber's name, if not patient:	Policy subscriber's DOB:
Patient's relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other, please specify:		

OTHER INFORMATION		
Pharmacy name:	Pharmacy location (address or intersection is okay)	Pharmacy phone no (if known) () -
Mail Order Pharmacy:		
How did you hear about our clinic, or who referred you here?		

SEGAL FAMILY MEDICINE CENTER

FINANCIAL POLICY AGREEMENT

We are doing everything possible to hold down the cost of your medical care due to increased demands for administrative services. You can help a great deal by eliminating the need for us to bill you. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our office manager. The following is a summary of our payment policy.

INSURANCE AND PATIENT RESPONSIBILITY

Payment is required at the time services are rendered unless other arrangements have been made in *advance*. This includes applicable coinsurance, copayments and deductibles for insurance companies we are contracted with. The practice accepts cash, personal check (in-state only), VISA, MasterCard, Discover and American Express. There is a \$35.00 service charge for returned checks.

INSURANCE: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, coinsurance, and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. *You are responsible for all your charges.* If you have insurance coverage with a plan for which we do not have a prior agreement or you have a pre-existing clause on your policy, the charges for your care and treatment will be due at the time of service.

PATIENT RESPONSIBILITY: In the event that your health plan determines a service to be “*not covered*” you will be responsible for the service performed. The physicians in the practice will be unable to change their “normal course of treatment” due to non covered services or limitations of your insurance benefits. Payment for non covered services will be due at the time of service or upon receipt of a statement from our office. Statement balances must be paid within thirty (30) days to avoid late payment penalty charges.

PAYMENT ARRANGEMENTS: Patients with an outstanding balance of 30 days overdue must make arrangements for payment prior to scheduling appointments. We realize that people have financial difficulty. Payments plans must be set up by the patient in person and will be automatically deducted by credit card/debit card. Other payment arrangements may be made on a case by case basis with the Office Manager.

REFUNDS: Refunds will be issued to accounts that have been finalized or paid completely by the insurance carrier and to patient’s who do not have future appointments already scheduled. Account credits less than \$20.00 will be used towards the patient’s next visit unless a refund is requested by the patient. Refunds are issued once a month.

MINOR PATIENTS: Regardless of marital status, we will look to the adult accompanying the patient for payment due at the time of service rendered to the minor patient. If a parent other than the one accompanying the minor patient to the office is legally responsible for the account a copy of the court decree will need to be submitted to the office. Otherwise, the accompanying parent will need to forward any payment requests to the responsible party.

OTHER SERVICES

REFERRALS: If you are a member of an insurance carrier that requires referrals to specialist or for radiology imaging, it is your responsibility to inform the office that you will need a referral or a prior authorization. Our office requires 48 hours notice of a requested referral and will not issue retroactive referrals.

MISSED APPOINTMENTS AND LATE CANCELATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Our office requires 24 hours notice of a cancellation. In the event that you miss or fail to cancel an appointment 24 hours prior there may be an administrative fee charged. The administrative fee is \$25-\$50 (depending on the type of appointment) and will need to be paid prior to scheduling future visits. Chronic rescheduling or missing of appointments may be grounds to terminate the physician/ patient relationship.

PRESCRIPTION REFILLS: Please allow 24-48 hours for a prescription refill. Prescription refills will be handled Monday-Thursday between 8:30 AM and 2:00 PM. Any refill request received after 2:00 PM will be handled the next business day. Due to having a limited staff on Fridays prescription refill requests will be handled the following Monday. If there is an urgent prescription refill request on a Friday a \$15.00 administrative fee will be charged. *New prescriptions will not be issued without first seeing your physician.*

PRESCRIPTION ADMINISTRATIVE FEES: Administrative fees may be charged if a refill prescription is issued without the patient seeing the physician, a new prescription is requested for mail order, additional “extra” prescriptions are needed or you are requesting a pharmacy change. The Administrative fee is \$15.00 for prescriptions 1-3 and \$25.00 for 4 or more medications. *We encourage our patients to make sure that they have enough medication to last them until their next visit and to also ask for mail order prescriptions at the time of the visit.*

PRESCRIPTION PRIOR AUTHORIZATIONS: Our office will only honor prior authorization requests from the patient. The patient will be responsible for contacting their insurance company to have them forward the prior authorization form to our office. The patient will need to ask their insurance company what “alternative medications” are covered on their plan. There will be a \$15.00 administrative fee for completion of a prior authorization form. Medication changes will not be done over the phone and if a medication change is requested the patient will need to make an appointment with their physician.

FORMS NEEDING COMPLETION: All forms including but not limited to school, daycare, camp physicals, prior authorizations, FMLA or disability paperwork will be subject to an administrative fee. The patient may need to schedule an appointment with the physician in order for him/her to complete the form. Administrative fees will be waived if the patient schedules an appointment with their physician. Please speak with the office manager if you have questions.

REQUESTS FOR MEDICAL RECORDS: In accordance with Texas law, Segal Family Medicine Center requires written request for the release of medical records. There may be an administrative fee associated with the release and will be based on current Texas law. Texas law allows 15 business days to get the requested copies to you. Please take this into consideration when requesting copies of medical records.

EMERGENCY REQUESTS: Any requests made by a patient that interrupts the physician’s day may be subject to a \$10.00 emergency administrative fee. This administrative fee will be due prior to the request being completed.

PATIENT/ RESPONSIBLE PARTY AUTHORIZATION

Please initial next to each individual agreement:

_____ **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Segal Family Medicine Center to: (1) release any information necessary to insurance carriers regarding my (or dependent) illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

_____ **AUTHORIZATION FOR ADMINISTRATIVE FEES:** I understand that I may be responsible for administrative fees incurred for completion of forms, missed or late canceled appointments and prescriptions. I agree to pay for these fees prior to the service being completed or further appointments being scheduled.

_____ **AUTHORIZATION FOR LABWORK:** Dr. Segal has ordered diagnostic and/or screening tests that are medically necessary. A claim for these services will be submitted to my insurance company within seven (7) days. I understand that I am financially responsible for the payment of these tests. Therefore, it is my responsibility to have these labs done within seven (7) days. If I fail to have these tests done, I do so at my own medical and financial risk.

_____ **AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:** I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to Segal Family Medicine Center. I hereby authorize and direct my insurance carrier, private insurance and other health/medical plan, to issue payment check(s) directly to Segal Family Medicine Center for medical services rendered to myself or my dependants regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Signature of Patient or Authorized Representative

Date

Printed Name of Patient

SEGAL FAMILY MEDICAL CENTER

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient acknowledges and agrees that Segal Family Medical Center may disclose Patients protected health information and patient medical record information to the following individuals who are the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient.

1.) Name: _____ Relationship: _____

Contact Information: _____

2.) Name: _____ Relationship: _____

Contact Information: _____

3.) Name: _____ Relationship: _____

Contact Information: _____

May we leave test results on any of the following: (Please initial the device(s) of your choice):

- _____ Home Answering Machine
- _____ Cellular Phone Voicemail
- _____ Work Voicemail or Answering Machine
- _____ Patient Web Portal

Please complete if you are over the age of 18

By signing this HIPAA disclaimer it allows our office to release your medical information to insurance, medical doctors and to whom you list above. It does not allow us to release these specific items listed unless you mark them. The Patient agrees that Segal Family Medical Center may disclose the following type of information, contained in the Patients medical records (please initial the appropriate categories that you choose to disclose listed below).

- _____ HIV/AIDS Information
- _____ Mental Health Information
- _____ Substance Abuse Information
- _____ Sexually Transmitted Disease Information
- _____ If Patient is under the age of eighteen (18), Pregnancy Information

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to Segal Family Medicine in writing.

Signature of Patient or Authorized Representative Date

Printed Name of Patient or Authorized Representative



Acknowledgement of Notice of Privacy Practices

I understand that as part of my healthcare, Segal Family Medicine Center originates and maintains paper and /or electronic records describing my health history, symptoms, examinations, test results, diagnosis, treatment and plans for future care and/or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which third party payer can verify that the services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality.

I understand that Segal Family Medicine Center maintains a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. The most recent version of this notice is displayed in the waiting room area. I understand that Segal Family Medicine Center reserves the right to change this notice and its practices as needed and will make a reasonable attempt to inform me of any changes. I understand that I can request an additional copy of this notice at any time. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent, and
- The right to request restrictions as to how my health information may be used or disclosed.

I have had the opportunity to receive and review the *Notice of Privacy Practices* of Segal Family Medicine Center.

Signature of Patient or patient’s guardian/representative

Date

Printed Name of Person Signing

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of our NPP, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other

Staff Member Name

Date



Segal Family Medicine Center, P.A.
 6537 Preston Road
 Plano, TX 75024
 Phone: 972 379-2096 · fax 972 379-2054

AUTHORIZATION OF RELEASE OF INFORMATION TO SEGAL FAMILY MEDICINE CENTER

I hereby authorize _____

Entity/Person from whom records are requested; include full name

Complete address

City, State, Zip, Telephone, Fax

I hereby authorize the above entity/ person to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Printed Name: _____ Date of Birth: _____ Social Security # _____

Patient Address: _____

Dates of Service (if known): _____ or ALL

Description of information to be released:

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Admission/Registration | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records | _____ |
| <input type="checkbox"/> Nurses’s Notes | <input type="checkbox"/> Physician’s Orders | <input type="checkbox"/> Laboratory Reports | _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Operative Records | <input type="checkbox"/> Billing Records | _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Reports | | |

Description of the purpose of the use and /or disclosure:

The health information described herein shall be released to:

Segal Family Medicine Center
6537 Preston Road
Plano TX 75024

Phone Number: 972-379-2096
Fax Number: 972-379-2054

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient’s Representative

Date

Printed Name of Patient Representative

Irwin M. Segal, M.D, C.M. · Aaron P. Segal, M.D. · Stephanie L. Segal, M.D.
 Anna Segal Practice Administrator, Gypsy Cassidy Office Manager