PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

I HAVE FILLED OUT MY MEDICAL HISTORY ON THE PATIENT PORTAL. YES ☐

PATIENT INFORMATION

Patient's Name: _____DOB: ____/____/____SSN: _____

Preferred Language (check one): English ☐ Spanish ☐ Other_____

INSURANCE INFORMATION

Insurance Company: _____

Subscriber's ID#: _____ Group#: _____

CIRCLE THE PROVIDER YOU'RE SEEING TODAY:

Ashley Chin, MD ☐

Australia Clark, MD ☐

Dr. Eric Tay, MD ☐

Tami Berkenhoff, PA ☐

Jennifer Quinones, PA ☐

Pinewood
MEDICAL CLINIC, P.A.

PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Pinewood Medical Clinic P.A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge that I have had the opportunity to view the Notice of Privacy Practices.

X_____ _____

Signature of Patient/Guardian Date

AUTHORIZATION OF MEDICAL INFORMATION TO A SECOND PARTY

I give my written authorization to release pertinent information regarding date and time of upcoming appointments, labs, diagnostic testing, referral information, and/or screening services.

You may release information to: (Name) _____

Relationship _____ Telephone Number: _____

X_____ _____

Signature of Patient/Guardian Date

PATIENT AUTHORIZATION

Notice of Privacy Practices

Your name and signature below indicates that you have been offered a copy of Pinewood Medical Clinic P.A.'s Notice of Privacy Practices. Contact Pinewood Medical Clinic at 936-321-3110.

Name (please print): _____

X_____ _____

Signature of Patient/Guardian Date

Assignment of Benefits, Financial Authority

I authorize Pinewood Medical Clinic P.A. to submit to my insurance carrier to evaluate claims for payment. I understand that if my employer is responsible for paying all or part of this claim, they will receive the medical information necessary to pay for it, and I authorize release of this information. I further authorize payment of benefits, otherwise payable to me, to be made payable to Pinewood Medical Clinic P.A. I understand that I am financially responsible for all charges not covered by my insurance.

If my insurance company is not in Pinewood Medical Clinic P.A.'s network or I have no insurance coverage, I understand that I am financially responsible for all charges and must make full payment today.

X_____ _____

Signature of Patient/Guardian Date

Consent for Medical Treatment

I give permission to Pinewood Medical Clinic P.A. to perform the medical and surgical processes, treatment, and/or procedures that the clinician and other non-clinicians and assistants may deem necessary. In addition, I authorize Pinewood Medical Clinic P.A. to release any information obtained during the course of my examination and/or treatment to my healthcare insurer or other payer.

X_____ _____

Signature of Patient/Guardian Date

PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. We require that you read and sign this policy prior to receiving any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, AND MOST MAJOR CREDIT CARDS.
All patients must complete our Patient Registration and History forms before receiving treatment.

PLEASE READ AND **INITIAL** EACH PARAGRAPH:

_____ INSURANCE PAYMENTS: If, for any reason, your insurance company does not render payment within thirty (30) days from the date of service, understand that you will be responsible for that unpaid balance.

_____ ALL NETWORK PLANS AND MEDICARE: We accept assignment of insurance benefits. However, if your insurance carrier has not made any payment within sixty (60) days from the date of service, you may be billed for the balance. If the insurance company does render payment, we will gladly refund the difference. Please be aware that some, and perhaps all, of services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other medical insurance. All co-pays/unpaid balances must be paid up front before treatment is received.

_____ SELF-PAY OR UNINSURED: If you do not have insurance coverage, or if Pinewood Medical Clinic P.A. does not have direct contact with your insurance company, you will be required to pay in full for your visit. An initial payment for medical care/treatment, the office visit fee, will be collected at check-in. Should your treatment require more complex evaluations, lab tests, vaccines, medications, x-rays, or supplies, you will be charged for those in addition to the appropriate office visit fee. These fees will be collected after service and treatment have been provided.

_____ HMO/POS POLICIES REQUIRING REFERRAL FROM PCP: It is the responsibility of the patient to obtain a written or verbal referral (whichever is required by the insurance carrier) prior to the patient's visit at a specialist's office. The specialist cannot obtain the referral for you.

_____ USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are not responsible for payment in excess of the insurance companies' determination of usual and customary rates.

_____ ADULT PATIENTS: Adult patients are responsible for full payment at time of service.

_____ MINOR PATIENTS: The adult accompanying a minor and/or the parent/guardian of the minor is responsible for full payment. For unaccompanied minors, all non-emergency treatment will be denied unless charges have been pre-authorized by the Financial Counselor or paid by check or credit card at the time of service.

_____ MISSED APPOINTMENTS: Unless cancelled within 24 hours in advice, our policy is to charge a $35.00 fee for missed appointments. Please help us serve you better by keeping scheduled appointments.

_____ DOCUMENT FEE: A documentation fee of $35.00 will be charged for all documentation that must be completed (Attending physician statements, letters of medical necessity, etc…).

Please let us know if you have any questions concerning our Financial Policy.
I HAVE READ THE FINANCIAL POLICY AND AGREE TO THE TERMS AS LISTED ON THIS PAGE.

_____ _____
Patient Name Relationship to Patient

X_____ _____
Signature of Patient or Responsible Party Date

PATIENT CENTERED MEDICAL HOME PATIENT COMPACT

A Patient Centered Medical Home is a trusting partnership between a doctor-led healthcare team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the roll of each in the total healthcare program.

We trust you, our patient, to:

- Tell us what you know about your health and illness
- Tell us about your need and concerns
- Take part in planning your care
- Follow the care plan that is agreed upon, or let us know why you cannot so we can try to help and change the plan
- Tell us what medications you are taking and ask for refill at your office visit when you need one
- Let us know when you see other doctors and what medications they prescribe you on or change
- Ask other physicians/specialist/facilities to send us a report about your care when you see them
- Learn about your insurance so you know what it covers
- Keep your appointment as scheduled, or call and let us know you cannot at least 24 hours in advance
- Pay your share of the visit fee at time of service
- Give us feedback so we can improve our service; our feedback box is in our waiting room.
- Visit our website at www.pinewoodmedicaltx.com and use the web portal to view lab results and chart information

As we build your Medical Home, there may be changes in how we provide care. However, we will continue to:

- Provide you with your own doctor who knows you and your family whenever he/she is available
- Respect you as an individual, we will not make judgments based on race, religion, sex, or disability
- Respect your privacy, your medical information will not be shared with anyone unless you give us written permission or it is required by law
- Provider care given by a team of people led by your doctor
- Give the care you need when you need it
- Give the care that meets your needs and fits with your goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours, 7 days a week
- Take care of short, illness, long-term disease and give advice to help you stay healthy
- Tell you about your health and illness in a way you can understand

Over the next several months, you may notice that:

- We ask what your health care goal is, or what you want to do to improve your health
- We use current best evidence in decision making about your care and offer support for self-management of your health and healthcare
- We ask you to help us plan your care and let us know if you think you can follow the plan
- We will give you a written copy of the care plan
- The team care members are doing more and/or different parts of the care
- We may ask you to have blood tests done before your visits so the doctor has the results at the time of your visit.
- We may offer you a chance to join in a special type of doctor visit called a “group visit”
- We continue to increase the use of technology in the way we manage your healthcare in ways such as ePrescriptions, eMessaging, and online bill pay (Via EMR and Patient Portal)

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, and we will acknowledge our agreement to you. Either you or your doctor may end this partnership at any time. If you choose to end the partnership, please notify us and tell us why. If your doctor decides to stop seeing you, we will notify you with an explanation as to why. With your written permission, we will forward a copy of your health records to your new physician.

Patient’s Name: _____DOB: _____

Patient Signature	Date	Physician Signature

PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

PATIENT MEDICATION HISTORY

NAME:	DOB: / /
SEX: MALE ◯ FEMALE ◯	

PRESCRIPTION MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

OVER THE COUNTER (OTC) MEDICATIONS

DRUG NAME	STRENGTH	FREQUENCY	PURPOSE

SUPPLEMENTS/HERBALS

SUPPLEMENT NAME	STRENGTH	FREQUENCY	PURPOSE

X_____ _____

Patient Signature Date

Reviewed By: _____ MD DO PAC FNP

PINEWOOD MEDICAL CLINIC P.A. | POLICY REGISTRATION FORM

HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION FORM

I hearby authorize use of disclosure of protected health information about me as described below. The following specific person or facility is authorized to make the requested use of disclosure:

REQUESTING RECORDS FROM:

Name of Dr. or Facility: _____

Address:_____

Phone No.:_____ Fax No.:_____

RELEASING RECORDS TO:

Name of Dr. or Facility: _____

Address:_____

Phone No.:_____ Fax No.:_____

Patient Name: _____ DOB:_____

Records requested (please check one):

☐ ALL MEDICAL RECORDS ☐ DIAGNOSTIC STUDIES OTHER:_____

☐ EKG ☐ BLOODWORK/LABS

☐ CONSULTATION NOTES ☐ IMMUNIZATION RECORDS

DATES OF REQUESTED RECORDS:_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying the above mentioned facility in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____ or one (1) year after the date of said authorization.

Signature of individual: _____ Date:_____ SSN or DOB:_____

If applicable (for minors)
Signature of guardian: _____Date _____ SSN or DOB:_____

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Healthcare System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Healthcare System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHiE.

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include this Consent in the individual's records.

Official Use Only:

MHiE
Memorial Hermann
Information Exchange

(Please print clearly)

Last Name

First Name

Middle Name

For Clinic/Office Use

Gender: Male Female

Date of Birth

Address

Apartment #

Telephone

City

State

Zip Code

County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (# C-7). The ImmTrac Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac. Once in ImmTrac, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): _____
Printed Name

_____ _____
Date Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EF11-13366
Revised 05/18/12

TEXAS Department of State Health Services

PROVIDERS REGISTERED WITH ImmTrac -- Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.