

SAI PRIMARY CARE

PATIENT REGISTRATION FORM

Patient Name: _____
Last First Middle

Date of Birth _____ Age: _____ Sex M / F Social Sec# _____

Address: _____
Street City State Zip

Responsible Party Name: _____ DOB _____

Address: _____

Employer: _____ WK Ph: _____

Social Sec. # _____

Home Telephone#: _____ Cell Telephone #: _____

Emergency Contact Person: _____ Telephone#: _____

Relationship to Pt.: _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of Policy holder

Date of Birth:

PRIMARY INSURANCE – Effective: ___/___/___	Secondary Insurance – Effective: ___/___/___
Insurance Co. Name: _____	Insurance Co. Name: _____
Group/ Plan # _____	Group/ Plan # _____
Policy/Member# _____	Policy/ Member # _____
Subscriber Name: _____	Subscriber Name: _____
Claim Address: _____	Claim Address: _____
_____	_____
_____	_____
_____	_____

The above information is true to the best of my knowledge. I authorize treatment for the individual above or myself and I understand that I am ultimately responsible for changes associated with medical services and authorize the physician and the clinic to release any information required to process my insurance claims. I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted disease, sickle cell anemia, or other sensitive information. I also authorize my insurance to directly pay The Prestige Medical P.A.

Patient/ Responsible Party Signature

Date

IMPORTANT INFORMATION:

**PARENTS PLEASE
BRING A COPY
OF YOUR CHILD'S
SHOT RECORD
EVERY VISIT**

**IT WILL HELP US KEEP
THEM
UP TO DATE**

SAI Primary Care

Acknowledgement – Notice of Private Practices (HIPPA)

Patient Name: _____

Date of Birth: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

1. I authorize the use or disclosure of the above name individual's health information as described below.
2. I understand the Health information Portability and accountability Act of 1996 (HIPPA) have certain rights to privacy regarding my protected health information. I understand that this information can be used to:
 - Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who maybe involved in that treatment directly and indirectly.
 - Obtain payment from third party payers.
 - Conduct normal healthcare operations such as quality assessments and physician certifications.
3. The type and amount of information to be used or disclosed is as follows:

_____ Complete health records	_____ Labs results/X-ray reports
_____ Physical exam	_____ Consultation reports
_____ Immunization record	
_____ Other (please specify): _____	
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.
5. I have received, read and I understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a correct copy of the Notice of Privacy Practices.
6. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payments or healthcare operations.
7. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing.

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____

PRESTIGE MEDICAL PA-SAI PRIMARY CARE
9233 BROADWAY, STE 107, PEARLAND TX 77584

**PATIENT AUTHORIZATION TO
DISCLOSE PERSONAL HEALTH INFORMATION**

Patient: _____
(First Name) (Middle Name) (Last Name)

Address: _____

Date of Birth: _____

Prestige Medical P.A. Is authorized to **furnish to / receive from** (circle desired choice):

Recipient/Discloser: _____

Previous Dr. Name and Phone Number _____

For the Purpose of: ____ (continuing care) _____

I AUTHORIZE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

Human Immunodeficiency Virus (HIV), alcoholism, I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to m in connection with any condition ore diseases. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning y treatment of illness, drug use/ dependency communications to social workers and/ or psychotherapies, psychologists, if any.

I GIVE PERMISSION TO RELEASE ONLY RECORDS

I release Prestige Medical P.A. and the Recipient/ Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from the authorization. I may withdraw this authorization at any time by giving written notification to Prestige Medical P.A. provided that I do so in writing and to the extend that you have already disclosed the information in reliance on this authorization

Parent Signature (Parent's Representative if minor)

Date

Witness Signature

Date

Birth History: Vaginal Delivery _____ C- Section Delivery _____

Developmental History: Sitting at _____Months Talking Few Words at _____Months
Walking _____ Months climbing _____Months

Chickenpox _____ Yes Date: _____ No _____

Surgery: _____

Immunization current not up to date unknown

Please answer the following questions regarding the patient’s behavior/social habits.

Is the patient having problems in any of the following

behavior interaction with peers school performance?

Please describe:

Is there any indication of past or present use of the following?

	Yes	No	If yes, please note frequency below
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Controlled substance	_____	_____	_____

The information is true to the best of my knowledge:

Patient/ Responsible Party Signature

Date

SAI PRIMARY CARE

PATIENT REGISTRATION FORM (CONT)

Sai Primary Care is committed to providing you with the best possible care. If you have medical Insurance we are eager to help you receive your maximum Allowable benefits. In order to achieve these goals, we need you assistance, And you understanding of our payment policy.

1. **CONTRACTED INSURANCE:** All insurance companies are billed Directly as a courtesy. Any remaining balance for non-covered benefits and deductible are your responsibility. Payment for this is expected within 30 days from receipt of your statement.
2. **CO-PAYS:** All co-pays are expected at the time the service is rendered.
3. **NON-CONTRACTED INSURANCE:** If your insurance company is not contracted with SAI Primary Care will provide you with a claim to sent to your insurance fore reimbursement. All Third Party Payers (motor vehicle accident insurance) are considered non-contracted.
4. **METHOD OF PAYMENT:** We accept cash, checks VISA, MasterCard or Discovered
5. **PAYMENT ARRANGEMENTS:** We understand that there may be times when financial difficulties come upon us without warning. Under special circumstances temporary payment arrangements may be made if approved in advance. Accounts on a temporary payment plan are required to make payment each and every month. Missed payments could result in collections. Accounts on a payment plan also must continue to pay at the time of the services. Our goals are to help you from attaining a greater debt and to assist you by keeping your account at a manageable level.
6. **RETURN CHECKS:** There will be a \$25.00 charge for all return checks.
7. **SERVICE FEE:** There is an interest fee accrued on ALL accounts with balances 60 days and over, regardless of payment arrangement or secondary insurance statue.
8. **DIVORCED, SEPARATED, OR BLENDED FAMILIES:** In order to keep accounts clean and eliminate any embarrassing or uncomfortable situation for you, we have chosen NOT to become involved in any agreements, understanding, and/or court order regarding reimbursement from the absent parent. Payment is required at the time of service. Reimbursement from absent parent is your responsibility.
9. **NO SHOW/CANCELLATION POLICY:** There may be a fee for no-show appointments or cancellation of appointments with 24-hour notice.

If you have any questions about the above information or any uncertainly regarding insurance coverage, Please don't hesitate to ask us. We are here to help you.

Patient/Responsible party Signature

Date

C.59 TVFC Patient Eligibility Screening Record

TEXAS VACCINES FOR CHILDREN PROGRAM (TVFC) PATIENT ELIGIBILITY SCREENING RECORD



Purpose: To determine eligibility and the source of funds for the Texas Department of State Health Services to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

Date of Screening: _____

Child's Name:

Last Name First Name MI

Child's Date of Birth: ____/____/____

Parent/Guardian/Individual of Record:

Last Name First Name MI

Provider's/Clinic's Name:

The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check the first category that applies, check only one)*:

- (a) is enrolled in Medicaid, or
- (b) does not have health insurance, or
- (c) is an American Indian, or
- (d) is an Alaskan Native, or
- (e) is underinsured (has health insurance that **Does Not** pay for vaccines, has a co-pay or deductible the family cannot meet, or has insurance that provides limited wellness or prevention coverage) *, or
- (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria, or
- (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP)
- None of the above, not eligible for TVFC vaccine

Signature: _____ Date: _____

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, 552.003 and 559.004)