FAMILY PRACTICE & BAYTOWN URGENT CARE
2800 Garth Road, Baytown, TX 77521
Tel: (281) 425-3800 Fax: (281) 425-3992

REGISTRATION INFORMATION

PATIENT DETAILS

Name _____ **Date** _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Age _____ Birth date _____ Sex: ❑ Male ❑ Female

Driver License # _____ Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Employer _____ Occupation _____

Employer Address _____ Phone _____

SPOUSE / GUARANTOR DETAILS

Name _____ Birth date _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____

Employer _____ Occupation _____

Employer Address _____ Phone _____

Who is responsible for this account _____ Relationship to patient _____

INSURANCE DETAILS

Do you have medical Insurance? ❑ Yes ❑ No

If Yes, Name of Primary Insurance _____

Policy # _____ Group # _____ Co-pay _____

Name of Secondary Insurance _____

Policy # _____ Group # _____ Co-pay _____

❑ Medicare # _____ ❑ Medicaid # _____

In case of Emergency, who should be notified _____

Relationship _____ Phone _____

Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Jacinto Medical Group,
Name of Insurance Company
all medical 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 my insurance submissions.

_____ _____
(Signature of Insured/Guardian) DATE

MEDICARE AUTHORIZATION:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jacinto Medical Group for any services furnished me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA – 1588 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination to the Medicare carrier as the full charge, and the patient is responsible only for the deductable, co-insurance, and non-covered services. Co-insurance and the deductable are based upon the charge determination of the Medicare carrier.

_____ _____
BENEFICIARY SIGNATURE DATE

FAMILY PRACTICE & BAYTOWN URGENT CARE
2800 Garth Road, Baytown, TX 77521
Tel: (281) 425-3800 Fax: (281) 425-3992

Patient Consent and Acknowledgment Form for Use and Disclosure of Protected Health Information

I hereby give my consent for Jacinto Medical Group, P.A. (JMG) , Jacinto Medical Corporation (JMC), and /or Baytown Urgent Care, Ltd.(BUC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided to me by JMG, JMC, and/or BUC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. JMG, JMC, and/or BUC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Cathy Rouse, Office Manager at 2800 Garth Road, Baytown, Texas or by calling (281) 425-3800** for further information**.**

With this consent, JMG, JMC, and/or BUC may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, JMG and/or JMC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, JMG, JMC, and/or BUC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that JMG and/or JMC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices and consenting to allow JMG, JMC, and/or BUC to use and disclose my PHI to carry out TPO.

Furthermore, I understand that JMG, JMC, and/or BUC have an electronic medical records system, which entails all of my private healthcare information. Within this electronic system, there is a function to include a digital photograph on each patient's chart. This photograph is solely used as to identify the patient upon reviewing the patient's chart. I hereby consent to JMG, JMC, and/or BUC and his or her assistants as necessary to photograph myself as the patient on record and to download onto my electronic medical chart.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If you do not sign this consent, or later revoke it, JMG and/or JMC may decline to provide treatment to me. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Signed by: _____ _____ _____
Signature of Patient or Legal Guardian **Date** **Relationship to Patient**

_____ _____
Printed Patient's Name **Print Name of Legal Guardian, if applicable**

_____ _____
Signature of JMG/JMC Authorized Representative **Date**

Consent to Treat

I hereby authorize and direct JMG, JMC, and/or BUC and his or her assistants as necessary to perform quality care, to perform the following procedures/treatment upon me:

[] Medical Care Visits [] Procedure/Treatment: _____

The nature and purpose of this procedure, alternative methods of treatment, and potential risks and complications listed below have been fully explained to me, including the

following:_____ procedure/ treatment(s) upon me.

I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of this procedure and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Print Name_____ Date of Birth_____

Signature _____ Date _____

Witness _____ Date _____

***If the patient is a minor or has a legally designated representative*:**

Print Patient Name_____ Date _____

Representative Signature_____

FAMILY PRACTICE & BAYTOWN URGENT CARE
2800 Garth Road, Baytown, TX 77521
Tel: (281) 425-3800 Fax: (281) 425-3992

Patient Financial Policy

Purpose:
To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions, regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard you complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or you health insurance carrier, full payment is due at the time of service. For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover.

Your Insurance:

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that you health care plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receive of a statement from our business office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody of payment.

I have read and understand the financial policy of the practice, and I to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

_____ _____ _____
Printed Name of the Patient Signature of Patient or Responsible Party Date

Assignment of Benefits

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Jacinto Medical Group, P.A., Jacinto Medical Corporation, and/or Baytown Urgent Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Jacinto Medical Group, Jacinto Medical Corporation, and/or Baytown Urgent Care, Ltd. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or 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.

I have requested medical services from Jacinto Medical Group, Jacinto Medical Corporation, and/or Baytown Urgent Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorization.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Signature Date

JACINTO MEDICAL GROUP

FAMILY PRACTICE
2800 Garth Road, Baytown, TX 77521
Tel: (281) 425-3800 Fax: (281) 425-3992

NEW PATIENT INFORMATION SHEET

OFFICE VISIT POLICY

If you are a new patient, we welcome you to Jacinto Medical Group. Our goal is to give you the most efficient and proper care. For existing patients, we thank you for your loyalty and hope we have and will continue to provide you with the best care. We ask that you arrive to every appointment at least 10minutes ahead of time. This will allow us to get you check in and verify your insurance, if need be. We do verify insurance information for all new patients and every 6 months thereafter. Please be prepared to show your insurance card at the time of each visit.

If you are calling in to schedule an appointment, please be prepared to confirm your current address, phone #, and date of birth. They will also confirm your current insurance information. .

WALK-IN CLINIC

For your convenience, if you are in need of medical attention due to an acute problem. We do have a Physician Assistant (PA) on staff that would provide the necessary care under the supervisor of JMG physicians on site. The clinic is opened 8:00AM - 11:30AM and 2:00PM - 4:30PM. This is on a walk-in basis, so please remember, you could wait an hour or so, but we strive for quick, yet personal attention.

REFILL POLICY

If a refill is needed, please allow us 24 hours notice to obtain approval from your physician. Please have the pharmacy send the refill request Electronically via Surescripts or Fax us at 281-425-3992. Routine medication refills will be filled from 8:30AM - 3:00PM weekdays only.

PATIENT MEDICAL QUESTIONS

If you have any questions regarding your medical care, please call our office during office hours (8:00-5:00) at 281-425-3800. You will then be transferred to the appropriate nurse's phone. If voice mail picks up, leave a message and the nurse will return your call in a timely matter. If it is an emergency, please state the problem, and we will have one of our staff members deliver the message to the nurse directly. If you have an emergency after hours, weekends, or holidays, you can contact the answering service at 713-935-2339. They will then page our on call physician for your call to be returned.

PATIENT ASSISTANCE PROGRAMS

We do offer a patient assistance program in our office for the patients that qualify for financial aide in obtaining their medications. We do this through www.needymeds.com. You may also go to www.needymeds.com for all the proper forms needed. If you are on this program and need refills, please call 3 weeks prior to your medication running out.

APPOINTMENT CONFIRMATION

We now have an electronic call system that will verify your scheduled appointment. Please listen to the message and press the appropriate button to confirm your appointment.

CANCELLATIONS

If you are unable to your appointment, please give us 24-hour notice so that we may fill that appointment time.

_____ _____

Patient Signature **Date**