REGISTRATION FORM – (PLEASE PRINT)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Race:	Ethnicity:					
Email:		Language:				
Street address: Apt #		Social Security:	Home ph: ( ) Cell ph: ( ) Work ph: ( )			
P.O. Box:	City:	State:	ZIP Code:			
Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:		Employer:	Employer ph: ( )			

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )
Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Patient's relationship to subscriber:

❑ Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

Patient's relationship to subscriber:

❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

Patient/Guardian signature *Date*

Liberty Dayton Medical Clinic

Consent for Treatment

I understand that if medical treatment is necessary, a physician, nurse practitioner, physician assistant, or other appropriate healthcare provider of the Liberty Dayton Medical Clinic will perform such medical treatment and procedures.

I understand that Nurse Practitioners (NP) and Physician Assistants (PA) are not physicians, but do function under the supervision of a physician, either directly or via protocols established by a physician and that the NP's or PA's are formally trained to provide diagnostic, therapeutic, and preventive health care services, as delegated by a physician. I also understand that as working as members of the healthcare team, NP's and PA's take medical histories, examine patients, order and interpret laboratory test and x-rays, and make diagnosis. They also treat minor injuries by suturing, splinting, and casting. NP's and PA's record progress notes, instruct and counsel patients and order and carry out therapy. I also understand that during my visit I may have an observer (student, surveyor, or other) approved by the facility to review the care given at any time.

Medicare/Medicaid Patient's Certification: Authorization to release information and payment request. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits: I hereby authorize payment directly to Liberty Dayton Medical Clinic of healthcare benefits otherwise payable to me including major medical insurance payment of surgical or medical benefits, including major medical, directly to the attending physician but not to exceed regular charges for these services. I understand that I am financially responsible to Liberty Dayton Rural Health Clinic and physician for charges not covered by this assignment.

Authorization for Release of Medical Information: The clinic and physician are authorized to furnish any medical information requested by insurance companies with whom I have coverage or any public agency, which may be assisting in my care.

Refund of Insurance Benefits: I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverage's are subject to a coordination of benefits clause.

I have read and fully understand the above Acknowledgement for Treatment and hereby grant my authorization and consent for such treatment and procedures.

Patient / Guardian Signature: _____Date: _____

Witness Signature: _____Date: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

PATIENT NAME_____

BIRTHDATE:_____SOCIAL SECURITY_____

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

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

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

LIMITED HEALTH CARE INFORMATION

Sharing of Information with Providers: You agree that Liberty Dayton Medical Clinic's staff and those who care for you will be able to access and share your health information with any physician or hospital that has treated you through CommonWell.

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship:_____

Name:_____DOB:_____Relationship:_____

_____ _____

Signature of Patient/Legally Authorized Representative Date

_____

(Relation if not patient)

*"Health Care Information" means information recorded in any form or medium that identifies that patient and relates to the history, diagnosis, treatment, or prognosis of the patient. It includes your medical record and any communicable disease information such as hepatitis and AIDS/HIV test results that may be reflected in the record.

**"Directory of Information" means (a) the fact that the patient is receiving hospital services, (b) nature of injury, (c) age, sex, and city of residence, (d) general health status (for example: "good," "fair," or "serious.") The only exception is if this information is otherwise protected by state or federal law (for example: HIV status, substance abuse diagnosis/treatment, or mental health information

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For Clinic Use only

_____ _____

(Witness and date) (Witness and date)

Medical History Questionnaire

Patient Name: _____ Date: _____
DOB: _____

Allergies: _____ ☐No Known Allergies

Pharmacy Name and Number_____

Medication Name	Dosage / MG	Times per day

Please mark an "X" by any of these conditions you may have had in the past:

☐Heart Disease
☐High Blood Pressure
☐High Cholesterol
☐Lung Disease
☐Diabetes
☐Thyroid Disease
☐Stomach Disease
☐Mental Health Problems
☐Sleep Apnea
☐Kidney, Bladder or prostate disease
☐Liver Disease
☐Bowel Disease
☐Cancer
☐Anemia or blood disorder
☐Blood Clots
☐Bleeding Tendency
☐Depression
☐HIV / Hepatitis C
☐Stroke
☐Seizure
☐Nerve impairment
☐Spine disease
☐Severe Headache
☐Tuberculosis / TB
☐Muscle Disease
☐Chronic Skin issues
☐Other:_____
_____

Surgical History:

_____
_____
_____
_____

Social History:

Do you smoke? ☐ Yes☐ No How many packs per day?_____

Do you use electronic cigarettes / vape? ☐ Yes☐ No # of cartridges a day? _____

Do you drink? ☐ Yes☐ No What Kind? _____

How much per day/week/month/occasionally _____

Do you use illicit drugs? ☐ Yes☐ No What kind? _____

How much per day/week/month/occasionally _____

Health Maintenance:

When was your last:

Tetanus Vaccine_____ **Women:** Pap smear _____ **Men:** Prostate Exam_____

Flu vaccine_____ Mammogram _____ PSA lab test _____

Colonoscopy _____ Last Period _____

Pregnancy History:

Number of Pregnancies? _____ Miscarriage? _____ Live births? _____

Disease	Mother	Father	Sibling	Grandparent
Alcoholism				
Anemia				
Arthritis				
Breast Cancer				
Cancer (what type)				
Dementia				
Diabetes				
Heart Attack				
Heart Disease				
High Cholesterol				
Hypertension				
Migraine				
Psychiatric Disorder				
Renal insufficiency (kidney disease)				
Respiratory Disorder (breathing)				
Stroke				
Thyroid Disorder				

Liberty Dayton Medical Clinic Patient Bill of Rights

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, beliefs, age, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be protected from neglect, exploitation and verbal, mental, physical or sexual abuse
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed via an appropriate referral to specialist.
- Refuse to participate as a subject in research.
- Be given full information and necessary counseling on the availability of known financial resources for care.
- Receive prior to treatment, a reasonable estimate of charges for medical care. An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- You have the right to express your concerns regarding the care and treatment that you have received in the clinic. The clinic's grievance process is handled by the Director of Nurses at 936-336-7316 ext.123. You also have the right to contact the

  Health and Human Services Commission
  Complaint and Incident Intake
  Mail Code E-249
  P.O. Box 149030
  Austin, Texas 78714-9030; by phone 888-973-0022

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**. "This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

  • Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

      - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

  If you believe you've been wrongly billed, you may contact

  Federal: https://www.cms.gov/nosurprises/consumers
  The federal phone number for information and complaints is: 1-800-985-3059. Texas - https://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html The state phone number for complaints is: 1-800-252-3439.