New Patient Registration Form

PATIENT INFORMATION:

Patient's Name _____ Marital Status _____ SS# _____

Mailing Address _____ City/State _____ Zip _____

Birth date _____ Age _____ Male/Female _____ Phone # _____

Employer _____ Occupation _____ Work # _____

Do you have an Advanced Directive (Living Will): ☐ Yes ☐ No Pharmacy _____

IF PATIENT IS A MINOR OR STUDENT:

Mother's Name _____ Birth date _____ SS# _____

Address _____ Phone# _____

Father's Name _____ Birth date _____ SS# _____

Address _____ Phone# _____

INSURANCE INFORMATION:

Primary Ins Company _____ ID# _____ Group # _____

Policy Holder's Name _____ Employer _____ DOB _____

Secondary Ins Company _____ ID# _____ Group # _____

Policy Holder's Name _____ Employer _____ DOB _____

EMERGENCY CONTACT (Person out of the Home)

Name _____ Phone# _____ Relationship _____

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Race: American Indian / African American / Alaskan Native / Asian / White / Native Hawaiian / Pacific Islander / Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to Report

Primary Language: English Spanish Other:

**Little Black Bag Provider will take a picture of ID & Insurance Card to upload to Patient Chart **

LITTLE BLACK BAG HOUSE CALLS

P: 940-249-5253 F: 940-249-5002

Consent to Treat & Non-Physician Provider Acknowledgement

Consent to Treat

I voluntarily consent, and hereby authorize employees and agents of Little Black Bag House Calls, LLC to render medical evaluations, health care treatment, and diagnostic procedures provided to, and on behalf of, the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency.

I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Little Black Bag House Calls.

I consent to the use, and disclosure, of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Little Black Bag House Calls Notice of Privacy Practices.

I give permission to obtain all of my medication/prescription history when needed to determine the best course of treatment.

Patient Name (Please Print)

Non-Physician Provider Acknowledgement

I understand that my Little Black Bag House Call Provider is **NOT** a physician, and I agree to authorize services rendered by Little Black Bag House Calls, LLC.

My signature below indicates that I understand the limitations of the services, that Little Black Bag House Calls is not an emergency service, and that I am instructed to call 911 in the case of an emergency. I also acknowledge that Little Black Bag House Call Providers do not operate as my Primary Care Provider and I have been instructed to notify my Primary Care Provider of any changes in my condition.

Patient Name (Please Print)

Signature of Patient, Parent, or Legal Guardian Date

Attach Supporting Documentation for Legal Guardian if necessary.

Assignment of Insurance Benefits/Eligibility Certification

☐ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Little Black Bag House Calls for any medical services rendered by it to me, or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

☐ I/We do hereby consent to and authorize the performance of all treatments, and medical services deemed advisable by the providers, and staff, of Little Black Bag House Calls, LLC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Little Black Bag House Calls to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

☐ I understand that if the above payment information given is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.

Signature of Patient /Responsible Party	Date
Name of Patient/Responsible Party (please print)	Relationship to Patient

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient

Patient Rights and Responsibilities

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, creed, age, sex or sexual orientation.
- 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 free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- 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.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

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.

As indicated by my initials, I have been informed of my Patient Rights & Responsibilities. _____

Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), Protected Health Information, under a federal health privacy law, as described below. I also authorize Little Black Bag House Calls, LLC to send over the visit notes to my primary care provider, home health agency, and other specialist I have listed that pertain to my current condition, following this visit.

I authorize Little Black Bag House Calls, LLC to release and obtain my private health information to (check all that applies):

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: Yes / No If yes:

_____

_____

No one other than myself may have access to my medical records: Yes/No

Communicating with You

☐ You may contact me by telephone Phone Number:_____
☐ You may leave a message/voice mail Phone Number:_____
☐ You may contact me by mail
☐ You may contact me through email

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient of Little Black Bag House Calls, LLC. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 901 Indiana Ave, Ste 540, Wichita Falls, TX 76301. I understand that my revocation will not affect any actions taken by Little Black Bag House Calls, LLC prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My provider will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed, or until revoked in writing. At which time this authorization to obtain and release this protected health information expires.

_____ _____

Patient Signature or Authorized Representative and Relationship Date

LITTLE BLACK BAG HOUSE CALLS

Patient History

Patient Name: _____ **Date:** _____

Have you ever had?	No	Yes		No	Yes	Are you experiencing?	No	Yes
Hypertension			Hepatitis			Chills		
Chest pain			Diabetes			Fever		
Heart Attack			Anemia			Shortness of Breath		
Irregular Heartbeat			Gout			Chest Pain		
Pacemaker			Thyroid Disease			Numbness		
Cardiac Defibrillator			Phlebitis			Extremity weakness		
Asthma			Stroke			Resting pain		
COPD/Emphysema			Cancer			Pain when walking		
Sleep Apnea			High cholesterol			Temporary blindness		
Kidney Disease						Slurred speech		

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			
Tobacco	☐Every Day Smoker ☐Some Day Smoker ☐Former Smoke ☐Never Smoked ☐Other: _____		

Past Surgeries	Date of Procedures

Allergies: _____

Current Physicians

Physician Name	Specialty		Phone Number

Other Health Care Providers

Home Health Agency:		
DME Company:		

LITTLE BLACK BAG HOUSE CALLS

Medication List

(Please Include all over the counter medications)

Medication Name	Strength	Frequency

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient