HMC

HOUSTON | SUGAR LAND

PATIENT REGISTRATION INFORMATION

PLEASE PRINT

Patient Name:_____ DATE:_____

Mailing Address:_____ City:_____ State:____ Zip:_____

HomePhone:_____ Cell/Work Phone#:_____

Date of Birth:_____ ****REFERRED BY:_____*****

Email Address: _____

EMERGENCY CONTACT (EC) NAME: _____

(EC) Phone Number: _____ Relationship to (EC): _____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

INSURANCE NAME: _____ **POLICY #:** _____

INSURANCE PHONE #: _____

RELEASE OF RECORDS

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OBTAINED AND DOCUMENTED BY HILLCROFT MEDICAL CLINIC DURING MY COURSE OF TREATMENT TO MY INSURANCE CARRIER.

Signature:_____ Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO HILLCROFT MEDICAL CLINIC. I REALIZE THAT I AM RESPONSIBLE FOR PAYING THE CO-PAYS, DEDUCTIBLE, CO-INSURANCE AND NON -COVERED SERVICES AS DETERMINED BY MY INSURANCE CARRIER.

Signature:_____ Date: _____

Dr. Susan Mathew, M.D. – Rheumatology 2500 Fondren Rd., Ste 209 Phone(713) 781-4600 Fax (832) 500-1365

MEDICARE LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND INFORMATION RELEASE

Patient's Name_____ Medicare I.D. number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (name of physician/supplier) for any services furnished me by that physician/supplier. 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 to 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-1500 claim 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 supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient's Signature Date

Hillcroft Medical Clinic Association

Patient Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Hillcroft Medical Clinic Association creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their Notice and will provide me with a new Notice of Privacy Practices if there are any changes.

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 healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.

2. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

(PATIENT'S NAME PRINTED) DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) DATE OF BIRTH

_____ _____

WITNESS (Optional) DATE

Hillcroft Medical Clinic

Dr. Susan Mathew

1429 Highway 6 Sugar Land, TX 77478

Ph: 832.500.1395 F: 832.500.1399

NO CALL-NO SHOW / SAME DAY CANCELLATION FEE

To provide effective efficient treatment to all our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time.

If an appointment is not cancelled, patient fails to show up for appointment or cancels appointment same day, Hillcroft Medical Clinic reserves the right to charge the patient a $50 fee per occurrence. As this fee is not billed to the insurance company, patient accepts full responsibility to pay this fee.

Signing this form also ensures verbal discussion and understanding of this policy.

If you have any questions about this form, please talk to us before signing.

Patient's Name: _____

Patient's/ Guardian's Signature: _____

Date: _____

Phone Message Consent Form

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.
- LEAVE INFORMATION ON AN ANSWERING MACHINE
- LEAVE INFORMATION ON A VOICE MAIL

Please read below and consider carefully whom you want to have access to your medical information.

I _____ give Hillcroft Medical Clinic Association and staff my permission to leave phone messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

Best Contact Number: _____ ☐ Cell ☐ Home ☐ Work

Alternate Contact Number: _____ ☐ Cell ☐ Home ☐ Work

In case I cannot be reached, a message may be left with (Name) _____
(Relationship) _____

My medical care may be discussed with the following:

Name: _____

Relationship: _____

Contact Number: _____

_____ _____
Patient/Guardian Signature Date