HealthcareAssociates of Texas

Patient Registration - Consent for Treatment

This for must be completed before seeing the Doctor to insure accurate records for your medical file and secure payment from your insurance company. Payment arrangements must be made at time of services.

HCAT Use Only: Chart Number: _____

Phone: _____ Fax: _____

Patient Information

Patient's Last Name: _____ First Name: _____ Middle Initial: _____

Social Security #: _____ Marital Status: _____

Gender: ☐ Male ☐ Female Age: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Mailing Address: _____

Residential Address (if different): _____

City: _____ State: _____ Zip: _____

Email Address: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

Insurance Information - Please give your Insurance Card(s) to the receptionist

Primary Insurance: (subscriber is the person who is the policy holder)

Policy Holder/Subscriber Name (if different from patient): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Patient's Relationship to Policy Holder/Subscriber: _____

Primary Care Physician if listed on the Insurance Card: _____

Secondary Insurance:

Policy Holder/Subscriber Name (if different from patient): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Patient's Relationship to Policy Holder/Subscriber: _____

Emergency Contact Information

Name: _____

Relationship: _____ Contact Number: _____

Provider or Referring Doctor Information

Which Doctor or Provider are you here to see? _____

Referring Doctor Name/Number: _____

Additional Information

Employer/Occupation: _____

Employer Contact Phone Number: _____

Are you an employee of Healthcare Associates or a family member of an employee? ☐ Yes ☐ No

If yes, whom are you related to and how are you related?: _____

How did you hear about us?

☐ Google Ad	☐ Google Search	☐ Social
☐ Family Friend	☐ Other Dr.	☐ Insurance Provider

I authorize the release of my medical information necessary to process this claim for payment of insurance benefits to HCAT. I understand I am responsible for all charges insurance does not pay including non-covered procedures. I also understand if the insurance information I provided is not correct this could result in my claims not being processed by the correct insurance carrier and I will be responsible for all charges. I consent to treatment as deemed necessary by HCAT providers and employees.

_____	_____	_____
Patient (Guardian) Signature	Printed Name	Date

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Patient History Form

This is a confidential record.
Information contained here will not be released to anyone without your authorization to do so.

Today's Date: _____ Date of last physical exam: _____

Last Name: _____ First Name: _____ DOB: _____

Current prescription medicines: ☐ None

Name of Drug	MG Dose	# Tablets	#Times/Day	Name of Drug	MG Dose	# Tablets	#Times/Day
1. _____	_____	_____	_____	4._____	_____	_____	_____
2._____	_____	_____	_____	5._____	_____	_____	_____
3._____	_____	_____	_____	6._____	_____	_____	_____

Past Medical, Family & Social History

List any personal past illness and/or surgeries and when they occured.

Illness or Surgery	Date	Illness or Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Tobacco Use? ☐ Never ☐ Occasionally ☐ Daily

Type of Tobacco Used: ☐ Snuff ☐ Dip ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ e-cigarette

Alchohol Use? ☐ Never ☐ Occasionally ☐ Daily ☐ Beer ☐ Wine ☐ Liquor

Illegal Drug Use? ☐ Never ☐ Occasionally ☐ Daily

List all chronic health illnesses in your immediate family (ex, diabetes, tuberculosis, breast cancer, heart disease, etc.)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Last Mammogram: _____ Last Pap: _____ Last PSA or Prostate Exam: _____

Last Bone Density: _____ Last Stress Test: _____ Last EKG: _____

Last Colonoscopy: _____

Are you on a special diet? ☐ Yes ☐ No (If yes, please explain): _____

Do you exercise regularly? ☐ No ☐ Daily ☐ Weekly ☐ Other: _____

Do you have allergies? ☐ Yes ☐ No (If yes, please explain): _____

_____

Advanced Directive? ☐ Yes ☐ No (Living Will)

Hepatitis A, B, C _____ Risks

Exposure to Hepatitis: ☐ Yes ☐ No

Tattoos? ☐ Yes ☐ No

Blood transfusion prior to 1992? ☐ Yes ☐ No

Immunizations (date)

Flu: _____

Pneumonia: _____

Diptheria/Tetanus: _____

Shingles: _____

Other: _____

Physician: _____ Date: _____

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Review of Systems

Do you know or have you had any problems related to the following systems? Check **Yes** or **No**

Patient Name: _____

Constitutional Symptoms
- Fever ☐ Yes ☐ No
- Chills ☐ Yes ☐ No
- Headache ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Eyes
- Blurred Vision ☐ Yes ☐ No
- Double Vision ☐ Yes ☐ No
- Pain ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Allergic/Immunologic
- Hay Fever ☐ Yes ☐ No
- Drug Allergies ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Neurological
- Tremors ☐ Yes ☐ No
- Dizzy Spells ☐ Yes ☐ No
- Numbness/Tingling ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Endocrine
- Excessive Thirst ☐ Yes ☐ No
- Too Hot/Too Cold ☐ Yes ☐ No
- Tired/Sluggish ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Gastrointestinal
- Abdominal Pain ☐ Yes ☐ No
- Nausea/Vomiting ☐ Yes ☐ No
- Indigestion/Heartburn ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Cardiovascular
- Chest Pain: ☐ Yes ☐ No
- Varicose Veins: ☐ Yes ☐ No
- High Blood Pressure: ☐ Yes ☐ No

Last Eye & Dental Exam
- Last Eye Exam - Date:
- Last Dental Exam - Date:

Pain
- Are you having pain? ☐ Yes ☐ No
- Is it adequately controlled? ☐ Yes ☐ No

Integumentary
- Skin Rash ☐ Yes ☐ No
- Boils ☐ Yes ☐ No
- Persistent Itch ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Musculoskeletal
- Joint Pain ☐ Yes ☐ No
- Neck Pain ☐ Yes ☐ No
- Back Pain ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Ear/Nose/Throat/Mouth
- Ear Infection ☐ Yes ☐ No
- Sore Throat ☐ Yes ☐ No
- Sinus Problem ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Genitourinary
- Urine retention ☐ Yes ☐ No
- Paintful urination ☐ Yes ☐ No
- Urinary Frequency ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Respiratory
- Wheezing ☐ Yes ☐ No
- Frequent Cough ☐ Yes ☐ No
- Shortness of breath ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Hematologic/Lymphatic
- Swollen Glands ☐ Yes ☐ No
- Blood clotting problem ☐ Yes ☐ No
- Other: _____ ☐ Yes ☐ No

Psychologic
- Are you generally satisfied with your life? ☐ Yes ☐ No
- Do you feel severly depressed? ☐ Yes ☐ No
- Have you considered suicide? ☐ Yes ☐ No

Sexual History
- Are you sexually active? ☐ Yes ☐ No
- Change in sex drive? ☐ Yes ☐ No
- Sexual performance satisfactory? ☐ Yes ☐ No
- Other (i.e. Sexual Trauma) ☐ Yes ☐ No

Physician use only: (comments/notes): _____

_____

Physician: _____ Date: _____

Financial Policy

Healthcare Associates of Texas and its affiliates recognizes the need for a clear understanding between our patients and their healthcare providers regarding protected health information and the financial policies related to the provision of healthcare services. We dedicate ourselves to providing the best possible care for you, and the information below is provided to avoid misunderstanding concerning our financial policies and associated protected health information.

1. **Payment:** Payment is due at the time of your visit. Payment includes any amounts due for copayments, coinsurance, unmet deductibles, non-covered charges and any balances from prior visits. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, paymnt in full is due at the time of your visit. We require you to present your insurance ID card and driver's license at registration due to the increasing frequency of identity theft.

2 **Insurance:** We are participating, in-network providers with most insurance plans. Please remember that you insurance is a contract between you and your insurance company. It is your responsibility to verify that we are a participating ("In-network") provider with your insurance. It is also your responsibility to understand what services your insurance coverage allows, and the financial responsibility you may have for such services. If your insurance plan requires a referral authorization from your primary care provider, please present this before receiving services or upon registration We will make our best estimate of the amount you owe for each visit prior to your arrival; however, any contractual amounts not paid by your insurance will be your responsibility. If your insurance company does not pay Provider within 60 days from receipt of a clean claim, the balance will become your responsibility. If we later receive payment from your insurer, we will refund any overpayment to you lest any outstanding patient balances.

3. **Secondary Insurance:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider, if applicable. Patient agrees to provide such information. Patient agrees to notify Provider of any future additions, changes or deletions of primary or secondary insurance coverage.

4. **Prompt Pay:** If you do not have insurance coverage, please be prepared to pay in full from your services at each visit. I understand that what is collected up front is only an estimate and I may get a bill.

5. **Returned Checks:** Returned checks and stopped payments will incur a $30 service charge and are subject to collections activity. You will be required to bring cash, certified funds or money order to cover the amount of the payment plus the service charge before receiving services from our staff or physicians. Stopped payments constitute a breach of our payment policies and bad checks are subject to prosecution in Dallas County.

6. **Accounting Principles:** Patient payments and credits for existing balances are applied to the guarantor's oldest charges first.

7. **Forms Fee:** Completing forms such as long-term care, life insurance, and Family Medical Leave Act (FMLA) (*Administrative Forms") requires considerable office staff time and time away from patient care for our doctors. Provider charges a processing fee of $25 per forms and completion fee of $5 per page (maximum $50 per form) for Administrative Forms. Payment is due at the time of the request. Provider will charge an additional fee for forms associated with special exam such as school, camp, sports participation and disability determination.

8. **Medical Records Copying:** Provider will not charge for transferring medical records directly to another physician's office. Provider charges $6.50 for the first (20) pages and $0.50 per page more than twenty form requests to copy and provide medical records for yourself in paper form. Provider will have 15 business days in which to copy records before making them available for the patient to pick up. These 15 business days will commence after payment for copying has been received and after the patient has signed on Authorization of Records Release Form. For an electronic copy of your medical record, Provider will charge $25.00 for the first 500 pages.

9. **Billing Office:** If you have questions regarding your billing statements, our accounts receivable staff is available to assist you. Call 972-594-1524 with any billing concerns.

10. **Cancellations or Missed Appointments:** If you do not cancel your appointment at least 24 hours in advance, or if you are a "no-show" we may assess you a $50 missed appointment fee. Multiple appointment cancellations or no-shows may lead to the dismissal of the patient from our practice.

11. **Responsibility for Payment:** I understand that I am financially responsible to Provider for charges not covered by the assignment of insurance benefits. Failure to keep your account balance current may require us to cancel or reschedule your appointment.

12. **Assignment of Insurance Benefits:** I authorize Provider to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. Provider will collect payment for supplies and services provided. I understand that I am financially responsible to the Provider(s) for the charges not paid or payable.

13. **Release of Information:** I authorize and direct Provider to release to government agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claims and payment.

14. **Collection Fees:** I understand if my account reaches collection status, any additional fees incurred due to this, will be added to my outstanding balance, including but not limited to late fees, collections agency fees, court costs, interest, and fines. I understand that these additional fees will be my responsibility to pay in full.

15. **Children of Separated or Divorced Parents:** By signing below, the parent or guardian who signs a minor child into our office on the initial visit accepts responsibility for payment for that visit. Provider is not responsible for sending bills or records to the other parent/guardian. We will communicate about treatment and payment with the parent or guardian who signs in the patient. Parents and/or guardians are responsible for communicating with each other about treatment and payment issues.

16. **Consent to Treatment:** I consent to treatment as deemed necessary by HCAT providers and employees.

I have read and understand the Provider's financial policy, and I agree to be bound by its terms.

I also understand and agree that the Provider may amend these terms from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

HCAT Physical Exam and Wellness Care Information

Annual physical exams/wellness care is strongly encouraged, especially in adults over the age of 40. HCAT providers encourage these exams yearly to help identify conditions early and to improve your overall quality of life.

Annual exams are used to:

- Screen and identify illnesses/disease processes, so that they can be treated early.
- Update medical history, family history, and any pertinent medical information.
- Screen for depression, falls, alchohol use, and other potential safety concerns.
- Provide necessary immunizations.
- Educate and encourage ways to improve and maintain a healthy lifestyle.

Annual exams are NOT used to:

- Discuss acute health problems. Depending on the acute need, the appointment may be converted to address that concern.
- Discuss new or changing chronic health conditions in detail.
- Because we know your time is valueable, your provider will discuss items outside of your physical only if time allows. Based on your insurance, this may generate an office copay or another appointment on another day.

Items included with annual exam:
Many insurance plans cover an annual exam at no cost to the patient. However, some plans limit the covered items to bare bones screening such as a chemistry panel, thyroid screening, and cholesterol screening. HCAT providers follow the best practices that they see fit for your health with the thorough and complete screenings based on your medical needs. For this reason, HCAT providers cannot, under certain circumstances, only deliver medical care that your insurance considers a “free” item. If you need care outside of the “free” physical, some of those elements may fall towards your deductible. This is not a Healthcare Associates policy. It is based on your insurance plan. Your provider will only order what is necessary for your care.

We have provided a list of some screening that may be performed at HCAT during a wellness visit. Please note that all screenings will not be performed on all patients. Screening are performed based on medical necessity.

Lab Tests: Complete Blood Count (CBC), Complete Metabolic Panel w/ Magnesium (CMP, Mg) Lipid panel (cholesterol), Thyroid screening, and urinalysis (UA). Additional lab tests may be performed based on current diagnosis, age, or clinical presentation.

Breast Exam/Mammogram: Female patients can receive a breast exam to check for abnormal lumps or any other signs of breast cancer. Mammography is typicaly started at age 40-50, and recommended every 1-2 years. Recommendations are based on your history, exam, and provider’s recommendations. If a mammogram is needed, an order will be placed at the time of your visit.

Pap Smear/Pelvic Exam: The pap smear is a screening for cervical cancer. Women should begin screening at 21 years or two years after becoming sexually active (whichever comes first). Subsequent screenings are recommended every 1 to 5 years, as recommended by your healthcare provider and results of your testing.

Testicular Exam: Men should be completing self-exams each month. Please discuss any lumps, changes in size, and/or tenderness with your provider.

Prostate Exam: In general, using the prostate-specific antigen (PSA) and digital rectal exam to screen for prostate cancer has pros and cons. It is recommended to discuss this with your provider. Screening is recommended to start at age 40-50, based on family history.

Colorectal Cancer for Screening: Screening for colon cancer usually begins at age 45-50. However, it may begin sooner based on family history and/or clinical presentation. There are options available for this screening, so pleae discuss with your provider.

Electrocardiograph (EKG/ECG): This test is performed on all men age 40 and over, and all women age 50 and over. This test detects abnormal heart rate/rhythm. If you are experiencing, or have a history of chest pain, please discuss with your provider. Additional testing may be indicated.

Chest X-Ray: Chest x-ray may be performed for those patients with a history of respiratory or cardiovascular illnesses.

Bone Density (DEXA Scan): Bone density screening is performed on women after menopause, to detect osteoporosis. Screening may be performed earlier, if clinically indicated.

Balance Testing/Fall Assessment: Balance testing is performed on all patients 65 years and older. This test evaluates balance, and determines those who are at an increased risk for falls. With early detection, various programs may be recommended, in order to decrease the risk for falls, and/or increase mobility and quality of life.

Retinal Imaging: Retinal scans are to be done on all diabetic patients at least yearly. Testing involves taking a photo of the retina, in order to view the vessels in the eye. Screening is performed even if you see an eye doctor yearly.

Sudoscan/SSR/QSART: QSART testing is performed to determine nerve damage. Screening is generally performed starting at age 65, on diabetic patients, or any patients with a known history of nerve damage/problems. Testing consists of placing the hands and feet on a metal plate, and sitting still for 3 minutes. Small nerve fibers and sweat production are evaluated to determine nerve response.

Ankle Brachial Indes (ABI): ABI testing is performed to determine vascular disease. This screening is generally performed starting at age 65, on patients with an increased risk of vascular disease (diabetes, hypertension, etc) or patients with a known history of vascular disease. This testing consists of 3 blood pressures taken on the right side of the body, followed by 3 blood pressures being taken on the left side of the body.

I have reviewed and understand the HCAT physical and wellness exam information provided to me:

_____ _____

Patient Signature Date