



# ALEDO FAMILY — MEDICINE —

## PATIENT INFORMATION

### PATIENT DEMOGRAPHICS

First Name:	Middle:	Last Name:
Date of Birth:	Sex:	Nickname:
Marital: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Social Security # :	
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:	Preferred Language:	
Preferred Phone Communication: <input type="checkbox"/> Leave a Message/Text with Detailed Information <input type="checkbox"/> Leave a Message with a Call-Back Number		

### FINANCIALLY RESPONSIBLE INFORMATION

First Name:	Last Name:	
Date of Birth:	Relationship to Patient:	
Phone:	Address:	
City:	State:	Zip Code:

### PATIENT INSURANCE | POLICY HOLDER INFORMATION

First Name:	Last Name:	Relationship:
Phone:	Date of Birth:	Social Security # :

Please bring the patient's current insurance card and a valid ID, to the front desk when checking in for the appointment.

### NOTICE OF PRIVACY PRACTICES

I have been given or a copy was available to me and I have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to evaluate and/or treat my condition, to process insurance claims on my behalf, and for other necessary health care operations of **Aledo Family Medicine**. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

### CANCELLATION POLICY FOR APPOINTMENTS

A 24 hour cancellation notice is required when a patient is unable to keep an appointment. It is the responsibility of the patient to notify our office. While we understand that unusual circumstances may force a patient to cancel their appointment last minute or no show, those patients can be charged a \$25 fee for each missed visit and/or dismissed from our practice for repetitive behavior. The office may also reschedule a patient's appointment if the patient is 15 minutes late for a scheduled appointment.

### MEDICATION REFILL POLICY

Please contact your pharmacy for medication refills 48-72 hours prior to running out of medication. Your pharmacy will send us an electronic request or fax in which the physician will review and respond within 48 hours. Please allow sufficient time for us to process your request.



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## **FINANCIAL POLICIES**

Notice: Our office does **NOT** file third party claims including auto insurance for motor vehicle accidents.

- I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless if they are covered by my insurance company, Medicare and/or supplemental policy.
- Payment is required at the time services are rendered. **Aledo Family Medicine** is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is estimated based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.
- Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- I understand that my I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for these services if they are not reimbursed by my insurance.
- I understand that a fee may be assessed for returned checks.
- Out of network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
- I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information.

The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent / Legal Guardian Printed Name:	Relationship:
Signature:	Date:



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## **PATIENT CONSENTS**

### **CONSENT FOR TREATMENT**

I authorize **Aledo Family Medicine**, its employees, and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition. The duration of this consent is indefinite and continues until revoked in writing.

### **CONSENT FOR FILING INSURANCE CLAIMS**

I understand that to file claims and release medical information to my insurance company, Medicare and/or supplemental policy, **Aledo Family Medicine** is required to keep my signature on file. I hereby authorize **Aledo Family Medicine** to receive benefits directly from my insurance company, Medicare and/or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (“AIDS”) and Human Immunodeficiency Virus (“HIV”). I also authorize **Aledo Family Medicine** to appeal any denials to my insurance company, Medicare and/or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and/or supplemental policy that is necessary for the processing of claims. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to **Aledo Family Medicine**. I further understand that should my account become delinquent, I shall pay the reasonable collection and attorney’s fees of **Aledo Family Medicine**, if any.

### **CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY**

I understand that to offer the best patient care, **Aledo Family Medicine** will retrieve my prescription history that has been ordered and filled through an EHR system and state registry. I authorize **Aledo Family Medicine** to import the prescription history obtained into my electronic chart.

### **CONSENT FOR REMINDERS / THIRD PARTY COMMUNICATIONS**

I authorize **Aledo Family Medicine** to send me appointment reminders, additional information regarding normal test results, preventative medicine, including health-related products or services and quality of care surveys provided by **Aledo Family Medicine** via automated SMS text messages, phone calls, voicemails, emails. I understand that message/data rates may apply under my cell phone plan. Neither opt-in nor any other mobile end user data will be shared with third parties for marketing purposes. I agree that affiliates may contact me through text messages, ring-less calls, and emails to provide me with my bill and to remind me to pay for services provided by **Aledo Family Medicine**, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive any and all communications.

The duration of this consent is indefinite and continues until revoked in writing.

Patient Printed Name:	Patient Date of Birth:
Parent/Legal Guardian Printed Name:	Relationship:
Signature:	Date:



## PHI COMMUNICATION PREFERENCES

I authorize **Aledo Family Medicine** to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals, as indicated below. This authorization is voluntary, and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my **protected health information (PHI)** may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

- I elect **not to authorize disclosure** to any individuals at this time
- I elect **to authorize disclosure** to the below list of individuals:

First & Last Name:	Relationship:	Phone:	Medical	Billing
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

I hereby consent to receive essentially normal test results, medication refills and appointment communication via detailed voice message and/or SMS text on the phone number indicated in this section. Msg frequency varies. Msg&data rates may apply. Neither opt-in nor any other mobile end user data will be shared with third parties for marketing purposes. **Leave blank if you choose to opt out of detailed voicemails/text.**

Phone:	
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**Emergency Only Contact Information** (no medical information, appointment or billing information will be released to emergency contact)

First and Last Name:	Phone:
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By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information. The duration of this consent is indefinite and continues until revoked in writing.

Home address:	Phone:	
City:	State:	Zip Code:
Email:		
Patient Printed Name:		Patient Date of Birth:
Parent/Legal Guardian Printed Name:		Relationship:
Signature:		Date:

**A. OUR COMMITMENT TO YOUR PRIVACY**

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights regarding your PHI
- Our obligations concerning the use and disclosure of your PHI

**The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.**

**B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Aledo Family Medicine  
317 FM 1187 N. Aledo, TX 76008  
817-441-7181

**C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:**

- 1. Treatment.** Our practice may use your PHI to treat you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment.
- 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us.
- 3. Health Care Operations.** Our practice, and its affiliated entities and management company, may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- 4. Appointment Reminders.** Our practice may use and disclose your PHI to contact you and remind you of an appointment. We will notify you about your appointment utilizing an automated phone system, a personal call, text or by mail. This notification may involve leaving a message on an answering machine or other automated or electronic equipment for such purposes, which could (potentially) be received or intercepted by others.
- 5. Sign in Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
- 6. Treatment Options.** Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
- 7. Health-Related Benefits and Services.** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- 8. Release of Information to Family/Friends.** Our practice will routinely disclose to your responsible party(ies) the PHI directly relevant to his/her involvement with your health care, PHI related to payment of your health care, and PHI used for notification purposes. Our practice may release your PHI to another responsible party(ies) you identify, that is involved in your care.
- 9. Marketing.** We may contact you to give you information about products or services related to your treatment, or care. We will not otherwise use or disclose your medical information for marketing purposes, without your prior written authorization.
- 10. Sale of Health Information.** We will not sell your health information without your prior written authorization.
- 11. Disclosures Required by Law.** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

**12. Breach Notification.** In the case of a breach of unsecured protected health information, we will notify you as required by law.

**13. Responding to Lawsuits.** We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**D. USE AND DISCLOSURE OF PHI IN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your protected health information:

- 1. Public Health Risk Reporting.** Our practice may disclose your PHI to public health authorities that are authorized by law. For example, we are required to report certain communicable diseases to the state's public health department.
- 2. Law Enforcement.** Your health information may be disclosed to law enforcement agencies, military, and national security without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- 3. Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs that provide benefits for work-related injuries or illnesses.

**E. YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you. These include:

- The right to request restrictions on the use and disclosure of your protected health information, including to request that a health plan not be informed of treatment for which patient paid entirely out of pocket.
- The right to prohibit the sale of your protected health information, its use for marketing purposes, or participation in research.
- The right to request to receive confidential communications concerning your medical condition and treatment in a specific manner.
- The right to inspect and obtain copies of your protected health information.
- The right to request an amendment or corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed outside of our practice if not for treatment, payment, or health care operations.
- The right to file a complaint if you believe your privacy rights have been violated. Please file your complaint in writing. You will not be penalized for filing a complaint.
- The right to receive a printed copy of this notice.

All requests must be in writing and directed to Aledo Family Medicine, 317 FM 1187 N. Aledo, TX 76008. Our practice may charge a fee for the costs associated with any request.

**F. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES.**

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

If you believe your privacy rights have been violated, you may complain to the secretary of the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or to the Compliance/Privacy Officer listed below. There will not be retaliation against you for filing a complaint. Again, if you have any questions regarding this notice or our health information privacy policies, please contact:

**Aledo Family Medicine  
317 FM 1187 N. Aledo, TX 76008**

**NOTICE OF PRIVACY PRACTICES**

**AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)**