Attached you will find the New Patient Sign Up Package

We ask that **<u>YOU DO NOT E-MAIL THIS PACKET</u>** to us as per

the Health Insurance Privacy Protection Act (HIPPA)

Instead you should:

1) Print out the forms and fill them out in its entirety
2) Bring the forms with you at your time of visit

or

3) **Fax** the forms to us prior to your visit at **956-425-3642**

For questions call 956-428-TAMI (8264)

Hope to see you soon!

New Patient Registration Form

Please complete in full

Date

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Age	Race	Ethnicity	Sex	Civil Status
	☐ African ☐ Asian ☐ Caucasian ☐ Native American ☐ Other	☐ Not Hispanic ☐ Hispanic ☐ Other	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Person Legally Responsible If other than patient	Language: ☐ English ☐ Spanish ☐ Other

Home Address (Include Apt. No.)

City	State	Zip Code	Home Phone
Social Security No.	**Driver's License No.**	**Cellular Phone**	**Business Phone**

Email Address: *(required to send you patient reminders on appt. and summary of visit)*

Employer

Employer's Address

Emergency Contact Person

Last Name	First Name	Middle Name	Phone:

Relationship:	Cell Phone:		

Address:

City, State, Zip

Referral

Referred by	Address

Authorizations

I hereby authorize Friendly Neighborhood Health Clinic to furnish information to Insurance Carriers concerning this illness/accident.

Patient's signature **X**

I hereby irrevocably assign to Friendly Neighborhood Health Clinic all payments for medical services rendered.
I understand that I am financially responsible for all charges not covered by Insurance.

Patient's signature **X**

I hereby give consent for treatment of my medic al problems to the health care provider of Friendly Neighborhood Health Clinic.

Patient's signature **X**

Name_______________________________________ Date ____________________

Date of Birth ____

" Have you or a"“blood” relative ever had the following	Yourself Yes	Yourself No	Relative Yes	Relative No	Relationship or Details	Doctor’s Notes
Diabetes	○	○	○	○		
Thyroid problems	○	○	○	○		
Dizziness or fainting	○	○	○	○		
Heart Trouble or chest pain	○	○	○	○		
High blood pressure	○	○	○	○		
Asthma	○	○	○	○		
Hay fever or allergies	○	○	○	○		
Bowel / GI disorder	○	○	○	○		
Stomach ulcers	○	○	○	○		
Bleeding or blood disorder / Anemia	○	○	○	○		
Cancer	○	○	○	○		
Blindness or Glaucoma	○	○	○	○		
Deafness	○	○	○	○		
Neurologic disease(including Seizures)	○	○	○	○		
Stroke	○	○	○	○		
Depression	○	○	○	○		
Nervousness	○	○	○	○		
Mental retardation	○	○	○	○		

	Yes	No	Hospitalizations/Surgery	Year
Arthritis or bone Disorder	○	○		
Hepatitis or jaundice	○	○		
Injuries other than strains or sprains	○	○		
Major or prolonged illness	○	○		
Blood transfusion	○	○		

Do you smoke or use oral tobacco?
Yes ☐ How long? __________
No ☐ Amount ______________
If quit, how long?_____________

Do you drink Alcohol?_________
Type _______Amount __________

Health Habits: Exercise _____ How Often: ______
Special Diet: ______________________________

Vaccines:
Shingles: ☐ Date:
Pneumonia: ☐ Date:

Do you have a history of substance abuse?
Yes ☐ No ☐

Coffee / other caffeine?
Amount ___________

Flu: ☐ Date:___ ___
Tetanus: ☐ Date: ___ ____

Current Medications:
(Please list all)
____
____
____
____
____
____
____
____
____
____
____
____

Drug allergies:
____
____
____
____

FOR WOMEN ONLY:
Age periods began ____________________
How long do they last __________________
How many days apart are they ___________
Menstrual problems ___________________
Date of Last Period___/____/____
Last Mammogram: ____/____
Last Bone Density: ____/_____

Number of pregnancies _________
Number of miscarriages _________
Number of children ____________
Planning children? _____________
Last pap smear __________
Last Colonoscopy __________

Do you have a designated medical power of attorney
Y N Who?____________________

Do you have a living will? Y N

HIPAA COMMUNICATION PROFILE

To insure compliance with current HIPAA guidelines, please provide us with the following information to confirm or establish your preferences for future confidential communications with our office.

Patient's Name (Printed): ______________________________ Date of Birth: ____ ____

Please provide your current telephone number(s) below:

Home Phone: ( ) Cell Phone: ( )

Work Phone: ( ) ______________ Other Phone: ( )

Current Address: ______________________________ City: __________

Email Address: ______________________

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday.
Please *check below* where you prefer to be called during these hours:

☐ Home Phone; ☐ Work Phone; ☐ Cell Phone; ☐ Other Phone

Your Protected Health Care Information Designees:

If you are not available at the time we call, please *check **below*** those individuals (designees) with whom we can leave a message or briefly discuss your medical information (e.g. lab or test results, prescription information). Please also **print** the name and telephone number of each designee below:

☐ My Spouse (Name):__________________________ Phone: ( ) -

☐ My Daughter (Name):__________________________ Phone: ( ) -

☐ My Son (Name):__________________________ Phone: ( ) -

____ Phone: ( ) ______________

OTHER DESIGNEE RELATIONSHIP

☐ Check here if ***you do not want*** your health care information discussed with anyone other than yourself.

Confidential Voice Mail/Mail:

Please *check below* where we have your permission to leave a confidential voice mail/mail (e.g. lab or test results). Leave the space blank if you do not wish to receive voice mails, or if you do not have voice mail.

☐ Home Voice Mail; ☐ Work Voice Mail; ☐ Cell Voice Mail ☐ U.S. Mail

Your signature below confirms your approval of these updated HIPAA communication preferences. You may change your selections at any time, but must do so in writing by completing an updated form.

____ __/ ___ /___

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE SIGNED

617 E. Loop 499 Suite C
Harlingen, TX 78550

HIPAA Notice Acknowledgment Form
Patient's Rights, Responsibilities, & Organizational Ethics

I am aware of the HIPAA Notice of Privacy Practices for Friendly Neighborhood Health Clinic and the copies of the notice are available for me to take upon request.

I have received a copy of the Patient's Rights & Responsibilities

______________________________	______________________
Print Patient Name	**Date of Birth**
______________________________	______________________
Signature of Patient or Parent/Guardian	**Date**

Estoy consiente del Aviso HIPAA sobre las Practicas de Privacidad por la oficina de Friendly Neighborhood Health Clinic y que copias estan a mi disposicion en cuanto las pida.

E recibido la copia de los derechos y responsabilidades del paciente.

______________________________	______________________
Nombre del Paciente	**Fecha de Nacimiento**
______________________________	______________________
Firma del paciente o representante	**Fecha**

617 E. Loop 499 Suite C
Harlingen, TX 78550

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

●As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
●Your insurance policy is a contract between you and your insurance company, the doctor is not involved.
●We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment at the time of the service.
●If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
●If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you. Therefore our charges or your care and treatment are due at the time of service.
●Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience we will accept most major credit cards
●All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge.
●For all services provided by our physician(s) in the hospital, we will bill your health plan. Any balance due is your responsibility.
●For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
●In order to provide the best possible service and availability to all our patients please call us as early as possible if you know you need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby state that I have listed ALL the MEDICAL INSURANCE COVERAGE that I currently have and I am aware of no other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this clinic of all medical coverages.

____

Signature of Party who filled out the registration forms and is responsible for this agreement

____

Please print name Today's Date

Patient Rights and Responsibilities

During illness, health-care providers have a special responsibility to be an advocate for patients and to assure that the patient's rights are protected.

As a natural outgrowth of our organizational values and mission, the medical staff affirm and recognize the following rights and responsibilities of patients:

- **In recognition of their human dignity, all patients have a right to courteous treatment and impartial access to quality medical care.**

- **All patients have the right to be informed of alternative treatments and to choose among the alternatives, including the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of their actions. All patients are responsible for their own actions if they refuse treatment or do not follow the doctor's recommendations.**

- **All patients have the right to every consideration of privacy concerning their medical care program. Patients are responsible for being considerate of the privacy of other patients. Telephones, televisions, radios and lights should be used in a manner agreeable to others.**

- **All patients are assured confidential treatment of their medical record by state and federal law. These statutes and regulations control the release of information contained in your medical record.**

- **All patients have the right to continuity of care, transfer and consultation with other medical specialties.**

- **All patients have the right to examine and receive an explanation of their bill, regardless of the source of payment. Patients have the responsibility to provide information necessary for claim processing and to be prompt in payment of their bills.**

- **All patients have the right to know the rules and regulations that apply to patient care and conduct and are responsible for following those rules and regulations.**

- **All patients have a right to receive an explanation of their treatment program and to ask for further clarification if the course of treatment is not understood. Patients have the responsibility to cooperate in their treatment program.**

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize Friendly Neighborhood Health Clinic to transfer, release or obtain information on:

______________________________ ______________ _____ _____ _____
(Name of Patient) (Date of Birth) (Social Security Number)

OBTAIN FROM:	**SEND OR FAX TO:**
______________________________	Friendly Neighborhood Health Clinic /Tami Dittburner, ANP-BC
(Physician/Institution)	(Provider)
______________________________	Medical Records
(Attention)	(Attention)
______________________________	617 E. Loop 499
(Address)	(Address)
______________________________	Suite C
______________________________	Harlingen, TX 78550
(City, State, Zip)	(City, State, Zip)
______________________________	956-428-8264 956-425-3642
(Phone) (Fax)	(Phone) (Fax)

For the purpose of:

____

Date(s) of Treatment: All dates: ☐ Specific Dates:_______________thru_______________

Please Check Specific Information Requested

__________All Records	__________Laboratory Reports	__________ Progress Notes
__________Discharge Summary	__________X-ray Reports	__________Operative Report
__________History & Physical	__________Emergency Room Report	__________Operative Notes
__________Pathology	__________ Nurses Notes	__________Endoscopy
__________Medication Records	__________ Nuclear Medicine Reports	__________

____ Other (Please Specify)

I understand that my records may contain but is not limited to: history, diagnosis, and/or treatment of HIV (AIDs virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for 90 days from the date of signature unless revoked in writing.
I have read and understand this consent and I have signed it voluntary.

______________________________ ____________________ __________
(Signature of patient or Parent/Legal Representative) (Relationship to Patient) (Date)

______________________________ ____________________
(Witness) (Date)

______________________________ ____________________
(Patient's Address, City, State, Zip) (Patient's Phone)