TODAY'S DATE: ________/________/________

ADULT CARE OF AUSTIN, PA

PATIENT INFORMATION

FULL LEGAL NAME		MAIDEN NAME:	NICKNAME OR NAME BY WHICH YOU WISH TO BE ADDRESSED:
DATE OF BIRTH:	SSN:	DRIVERS LICENSE #	STATE OF ISSUE IF NOT TEXAS:

MAILING ADDRESS:	CITY/ STATE/ ZIP

GENDER:: Male Female YOU ARE: Single Married Widowed Divorced RACE: Indian Asian Black White Hispanic	NATIONALITY: American Mexican Asian LANGUAGE: English Spanish Other: DOMINANT HAND: Right Left

HOME / CELL PHONE:	May we leave a voice message regarding appointment confirmations and request for you to call our office?	YES NO
( ) ________- __________	May we leave a message with any individual who answers this phone regarding appointment confirmation or the need for you to call our office?	YES NO
WORK / OTHER PHONE:	May we leave a voice message regarding appointment confirmations and request for you to call our office?	YES NO
( ) ________- __________	May we leave a message with any individual who answers this phone regarding appointment confirmation or the need for you to call our office?	YES NO
E-MAIL ADDRESS:	May we send an email message or reminder to you?	YES NO

DRUG ALLERGIES

& SENSITIVITES:

PRIMARY PHARMACY	Address/Location	Pharmacy Phone	☐ Local ☐ Mail order
ALTERNATIVE PHARMACY	Address/Location	Pharmacy Phone	☐ Local ☐ Mail order

REGARDING YOUR CONFIDENTIAL PATIENT INFORMATION: (OPTIONAL)

I permanently authorize Adult Care of Austin staff to discuss any/all aspects of my confidential medical care (emergent and non-emergent) with the following individual(s):

Name: ____ **Relationship:**______________________________ **Phone:**________________________________

Name: ____ **Relationship:**______________________________ **Phone:**_______________________________

OUR COMMUNICATION POLICY:

In the event of a medical crisis, we ask that you designate ONE family member or loved one with whom we can communicate. This individual (designated below) will be responsible for passing on all information to the rest of your family:

NAME:	RELATIONSHIP:	PHONE #1:	PHONE #2

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST FOR IMAGING

PRIMARY INSURANCE:	If you are NOT the policy holder, what is the policyholder's name AND date of birth?
SECONDARY INSURANCE:	If you are NOT the policy holder, what is the policyholder's name AND date of birth?
TERTIARY INSURANCE:	If you are NOT the policy holder, what is the policyholder's name AND date of birth??

NOTIFICATIONS AND ATTESTATIONS

INSURANCE ATTESTATION AND BENEFITS ASSIGNMENT AGREEMENT

I verify that the insurance cards presented today are an accurate and complete representation of my personal medical insurance coverage. I verify that I have no other health insurance coverage other than those named above. I authorize Adult Care of Austin, PA to apply for benefits on my behalf for covered services rendered either by professional or professional order and request that payment is made directly to the professional association. I authorize the release of any medical information necessary to process claims. I understand that I am responsible for payment of any insurance deductible, coinsurance, copayment and/or services that are not covered due to contractual limitations. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________ **Date:** ______________.

PHYSICIAN EXTENDERS

I authorize Adult Care of Austin, PA physicians to instruct their Physician Assistant (PA) or Advanced Practice Nurse (NP) to assist them in my medical care. I understand that a PA or NP is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision of a licensed physician. I further understand that I may revoke the authorization at any time. I permit a copy of this authorization to be used in place of the original.

Signature: ______________________________ **Date:** ______________.

PERSONAL HEALTH INFORMATION (PHI)

Adult Care of Austin, PA strictly adheres to federal privacy laws regarding your protected health information. Please sign below to indicate that you have been provided and read Adult Care of Austin *Notice of Privacy Practices*.

Signature: ______________________________ **Date:** ______________.

DRUG VERIFICATION

For your safety and in the interest of providing the highest quality medical care, Adult Care of Austin providers routinely attempt to verify use of all drugs (prescription, over-the-counter, supplements and alternative/herbal). In addition to patient/family-supplied information, we may also contact a pharmacy, pharmacy/prescription clearinghouse or prescription benefits manager. Please sign below to indicate your acceptance and consent of this policy.

Signature: ______________________________ **Date:** ______________.

NO-SHOW FEE

Beginning September 1, 2022.

We will require a 24 hour Cancellation Notice for All Office Appointments.

If the required notice is not given, a $50.00 charge will be assessed to the patient account. The missed appointment charge must be paid prior to or upon the next office visit.

Signature: ______________________________ **Date:** ______________.

ELECTRONIC STATEMENTS

Adult Care of Austin, PA sends electronic statements via the patient portal. You will receive an email notice that a statement has been generated for your account. .

Signature: ______________________________ **Date:** ______________.

INTERNAL USE ONLY:

EMPLOYEE SIGNATURE:

☐ **PATIENT PORTAL ACCOUNT HAS BEEN ESTABLISHED:**

☐ **EMR REGISTRATION COMPLETE**

☐ **TEXAS IMMTRAC2 REGISTRATION COMPLETE**