PATIENT REGISTRATION FORM

Today's Date: _______________ **Clinic Location (circle one):** College Station Columbus Bastrop Mexia Brenham La Grange

PATIENT INFORMATION: (Please use full legal name) * **REQUIRED FIELDS**- PLEASE COMPLETE FOR BILLING

*Last Name: __________________________________ *First Name:___________________________________ Middle Initial: _________

* Address: ____

City: _________________________________ State: _______________ Zip: _______________

*Date of Birth: _____/______/_____ *Sex: ________ Marital Status: ____________ Drivers Lic #:__________________

*Home Phone #: (_____) ______-_________ *Social Security #: ______-______-______*Cell Phone #: (_____) ______ - _________

Email Address: ____ Preferred Pharamacy:_________________________________

Emergency Contact Name: __________________________ Relation:______________ Emergency Phone #: (_____) ______-________

Referred By: ______________________________________ *Primary Care Physician: _____________________________________

GUARANTOR INFORMATION: (List person who is responsible for the bill. Parent/Guardian put your name if patient is under 18)

*Relationship of Guarantor to Patient: Self______ Spouse______ Parent______ Other____________

*Last name_____________________________________*First Name___________________________________ Middle initial: _________

*Address____

City:____ State:______________ Zip: _________________

*Home Phone #: (_____) ______-_________ *Social Security #: ______-______-______

*Date of Birth: _____/______/_____ *Sex: ________ Work Phone #: (_____) ______-_________

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURAED PARTY PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INSURANCE:

Plan Name: ____*Insured's Name: ____

*Insured's Social Security #: ______-______-______ * Insured's *Date of Birth: _____/______/_____

*Policy/ ID #: ____________________________________ *Group #_______________________ Eff Date: _________________

Medicaid Plan: ___________________________ Medicaid ID #: ____________________ Eff Date: ______________

SECONDARY INSURANCE:

Plan Name: ____ *Insured's Name: ____

*Insured's Social Security #: ______-______-______ * Insured's *Date of Birth: _____/______/_____

*Policy/ ID #: ____________________________________ *Group #_________________________ Eff Date: _________________

Patient / Guardian Signature: ____

Acceptance of Financial Liability

Central Texas Sinus & Allergy
2805 Earl Rudder Frwy S
College Station, TX 77845
Ph 979-764-3090 Fax 979-764-3172

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding my health Insurance Plan(s) or any other health maintenance originations to which I may be entitled to benefits. I hereby assign payment(s), if any, from my health Insurance Plan(s) to Central Texas Sinus & Allergy (or its affiliate) for services rendered to me. The direct payment hereby assigned and authorized includes any health Insurance Plan(s) benefits to which I am otherwise entitled, including any medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to Central Texas Sinus & Allergy (or its affiliate), for services rendered to me during the applicable periods of medical care.

2. Insurance verification, **Referrals and Prior Authorizations**- I understand that Central Texas Sinus & Allergy is accepting me as a patient and I will be responsible for paying for all services rendered. I understand it is my responsibility to verify my health insurance benefits with my health Insurance Plan(s) to obtain any co-pays, deductibles, or out of pocket expenses I may incur. I also understand that it is my responsibility to obtain a referral from my PCP or verify a prior authorization was approved for all services to be rendered if required by my health Insurance Plan(s).

3. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my health Insurance Plan(s) does not consider this office visit or any service rendered during this office visit or outpatient service a covered service or has not authorized this service, they will not pay for this office visit or the service rendered during this office visit or outpatient visit. If services are filed to my health Insurance Plan(s) and are partially paid or denied because they were deemed out of network, not medically necessary, have reached a maximum benefit, or were denied because my health Insurance Plan(s) was not in effect at the time of service or a referral was not received before services were rendered, I understand that I will be financially responsible for these services. I agree to be fully responsible for payment to Central Texas Sinus & Allergy for this office visit or any service rendered during this office visit or outpatient visit if determined by my health Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

4. Central Texas Sinus and Allergy- will send a financial statement to all patients on a monthly basis for any services rendered that are not covered by a health Insurance Plan(s) or government Insurance Program, is out of area for their Medicaid managed care plan, received services for a non-covered procedure, have reached a benefit maximum, has a service that is deemed not medically necessary, had a change in Insurance Plan(s) and failed to notify us in a timely manner, or have been informed that our facility or Physicians are not an approved provider for your health Insurance Plan(s). We will also bill on a monthly basis any unpaid co-payments, Insurance Plan(s) deductibles, and co-insurance, records request fees, NSF fees, No Show fees along with any other unpaid balance. Payment for these services is expected within 30 days of receipt of the statement. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Central Texas Sinus & Allergy. I understand and agree this document will remain in effect for all future outpatient or physician office visits to Central Texas Sinus & Allergy, unless specifically rescinded in writing by me.

Patient Signature: ____ **Date**: ______________________

Guarantor/Relationship to Patient: ___________________________________/________________________

Patient Consent for Use and Disclosure
Of Protected Health Information

I hereby give my consent for **Central Texas Sinus and Allergy** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by **Central Texas Sinus and Allergy** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Central Texas Sinus and Allergy** reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Diana Northup at 2805 Earl Rudder Freeway South, College Station, Texas 77845.**

With this consent, **Central Texas Sinus and Allergy** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Central Texas Sinus and Allergy** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Central Texas Sinus and Allergy** may e-mail to my home or other alternative location any items that assist the practice in carrying out TOP, such as appointment reminder cards and patient statements. I have the right to request that **[Insert name of practice]** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Central Texas Sinus and Allergy** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon to my prior consent. If I do not sign this consent, or later revoke it, **Central Texas Sinus and Allergy** may decline to provide treatment to me.

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually. Your rights are posted in the waiting rooms at each Physicians clinic. Copies of the rights are also available at the receptionist desk if you would like to keep this information for your records. I authorize **Central Texas Sinus and Allergy** to release any of my medical or insurance information necessary to process my medical claims and coordinate/manage my healthcare.

With whom may we discuss information about your care, treatment or diagnosis?

Name:____ Relationship:________________________

Name:____ Relationship:________________________

Name: ____ Relationship: ________________________

I, ____ (Patient/Guardian) acknowledge the HIPAA Patient Rights and Privacy forms. I have read and understand my rights.

Signature: ____ Date:____________________