TEXAS A&M PHYSICIANS
TEXAS A&M HEALTH SCIENCE CENTER

PATIENT INFORMATION

First Name: _____Middle:_____Last:_____

Date of Birth: ____/_____/_____ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Address: _____ ZIP: _____

City: _____ State: _____ County: _____

Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____ Pager ____ Fax

Alt Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____ Pager ____ Fax

Alt Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____ Pager ____ Fax

Email: _____@_____._____

Contact me by: ____ Secure Message ___Letter ___Home phone ___Email ___ Cell ___ Work ___ Pager

Sex: ___ Male ___ Female Social Security Number: _____-_____-_____

Referring Provider: _____

Language: _____

In order to comply with Federal Regulations, we have been directed to collect information from our patients on their race and ethnicity. Please select from the following Federal approved choices:

Race: _____ American Indian or Alaska Native _____ Asian_____ Black or African American

_____Native Hawaiian or Other Pacific Islander ____ White _____ Other

Ethnicity : _____ Hispanic/Latino _____ Not Hispanic/Latino

If Minor or Student:

Parent Guardian Name: _____

Date of Birth: _____/_____/_____

Address: _____ ZIP: _____

City: _____ State: _____ County; _____

Relationship to patient: _____ Social Security Number ____-____-____

Phone: (_____) _____-_____ Type: ___ Home ____ Cell ____Work ____ Pager ____ Fax

Emergency Contact (not self/parent): Name _____

Address: _____ Zip: _____

Relationship: _____ Phone: (_____) _____-_____

Pharmacy:

_____

_____

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Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT AND CONSENT OF RECEIPT OF NOTICE OF PRIVACY

I have reviewed Texas A&M Health Science Center's Notice of Privacy, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at no cost to me.

Patient requested copy: ____ Yes ____ No

CONSENT FOR PRESCRIPTION RECONCILIATION

I, _____, hereby consent to have my prescription history reconciled via pharmacy billing information.

CONSENT TO RELASE MEDICAL INFORMATION TO PERSONAL REPRESENTATIVE

I, _____, hereby consent to have my information released to the following individuals. This consent will remain in effect until otherwise notified by me in writing.

____ Appointment times ____ Medical Information ____ Billing/Demographic Information

____ Do NOT release any information, except to healthcare providers

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

CONSENT AGREEMENT FOR TELECOMMUNICATIONS/EMAILS

I authorize Texas A&M Physicians to send text messages and/or emails regarding appointment reminders to me/representatives on the provided cell phone number and/or email. By accepting these terms, I agree that all individuals associated with my account may receive alerts referencing the account guarantor and/or dependents. Text message charges from my cell phone provider may apply.

(_____)_____-_____ _____@_____._____
Patient's/Guardian's Cell Phone *Patient's/Guardian's Email*

(_____)_____-_____ _____@_____._____
Authorized Individual's Cell Phone *Authorized Individual's Email*

_____ _____
Authorized Individual *Relationship*

My signature below indicates that I represent and warrant that I am the person legally responsible for all use of the accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text message services. I understand that this authorization can only be revoked in writing. *It is important to know that text communication is not always secure. Text messages can be intercepted and for this reason, we do not communicate personal health information through this method.*

_____ _____
Name of Patient (Please Print) *Date*

_____ _____
Signature of Patient or Legal Guardian *Relation to patient (Self, Mother, Father, Guardian)*

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Patient Name: _____ DOB: _____

FINANCIAL AND CONSENT AGREEMENT

ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE

- Services are rendered to the patient, not the insurance company. Our office will file your insurance if proper information is received.
    - You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance.
    - For unpaid claims over 45 days, it is your responsibility to follow up with your insurance company and the balance may be considered due and payable.
- It is your responsibility to notify the office of any changes in your insurance or demographics.
- You will be responsible for any charges that occur if changes to your current insurance are not communicated at the time of service.
- Expenses occurred to collect patient-responsible debt may be charged to the patient or guarantor.

I, _____, (if minor, for _____) hereby voluntarily consent to medical treatment, including diagnostic procedures, surgical and other medical services, provided by Texas A&M Physicians or their authorized designees, as they may in their professional judgment be necessary to prove appropriate medical, surgical or emergency care.

I authorize Texas A&M Physicians to submit claims to my insurance company for services rendered by my medical providers.

I authorize the release of any medical information necessary in order to process this assignment on the claim.

I authorize payment be made to Texas A&M Physicians for services provided by them.

_____ _____

Signature of Patient/Legal Guardian/Authorized Representative Date

_____ _____

Name of Legal Guardian/Authorized Representative Relationship to Patient

TEXAS A&M PHYSICIANS
TEXAS A&M HEALTH SCIENCE CENTER

OFFICE HOURS: Our Family Medicine clinics are open Monday-Friday from 8:00 a.m. - 5:00 p.m.

AFTER HOURS CARE: There is always a physician on call for every provider, he/she will do their best to help you, but there are limitations to practicing medicine by phone and it is best for a provider to directly examine you. The on call physician may direct you to another location, Express Care location, or to one of the Emergency Rooms.

*******PLEASE REMEMBER TO BRING PAST MEDICAL AND OR VACCINATION RECORDS, ALL MEDICATION(S), INSURANCE CARD AND PHOTO ID. TO YOUR APPOINTMENTS*******

All new patients are encouraged to be at least 30 minutes early to their appointment to fill out new patient paperwork.

All established patients are encouraged to be 10-15 minutes early to their appointment.

LATE PATIENTS: We will do our best to be accommodating as we know sometimes things happen.

- If you are 10 minutes late, we will do everything we can to keep your appointment, however we may ask you to reschedule if we are heavily booked for that day.
- If you are 15 minutes late to your appointment, the staff will inform you that you MISSED your appointment and one of the following will occur:
    - Reschedule your appointment to next available appointment with your PCP *which could be a cancellation or other open appointment on the same day.*
    - Reschedule you with another provider if an open time slot is available.

CANCELLATIONS: Please call at least 24 hours before your appointment if you are unable to keep. This allows us to provide that time slot to another patient.

TREATMENT OF MINORS: Patients under the age of 18 must be accompanied by a parent/guardian or have written permission for treatment from a parent/guardian if accompanied by other adult for every visit.

CELL PHONE USAGE: In order to provide the best care possible, we request no cell phone usage during patient visits. It is in the interest of your safety that you provide your full attention to your provider and be an active participant in your treatment plan.

MEDICATIONS: Please bring **all your current medications** with you **to every appointment**. We ask you to bring your medications in the original bottle(s) so we may verify each medication's name, dosage, etc. This information will allow your provider to better care for you. We may not refill a specific medication if the medication bottle was not brought into verify the medication, dosage, etc.

PRESCRIPTIONS AND REFILLS: The best time to get a prescription refill is at your appointment. If you need a refill please contact your pharmacy and ***allow 72 hours for processing***. DO NOT wait until you have run out of medication. Some medications have potential side effects that must be monitored. We

require check-ups every 3-4 months for these medications. Be sure to keep these follow-up appointments. Some prescriptions cannot be called in; these are controlled substances that require a triplicate prescription. The prescription must be written for you to pick up and ***will be processed within 72 hours***. You are required to bring a photo ID each time you pick up these prescription(s).

CONTROLLED SUBSTANCES PRESCRIPTIONS: We DO NOT call in Controlled substances after hours. Controlled substances may be prescribed by our physicians, but only after an evaluation has been performed. The ***medications will be processed within 72 hours***, if prescribed. If you require chronic use of controlled substances, our physicians may refer you to a pain management specialist. You may also be asked to agree to a controlled substances/pain medicine contract.

DISMISSAL FROM THE PRACTICE: Please note that we reserve the right to dismiss a patient from the practice for certain behaviors,

- Appointment Noncompliance: Failure to keep appointments.
- Treatment Noncompliance: Failure to follow physician instructions or treatment plan about an important health issue.
- Controlled Substance Abuse: Patient abuses controlled substances, including ADHD medications or controlled substances.
- Verbal Abuse: Patient or family member uses improper or abusive language with office personnel/provider(s), or exhibits violent or threatening behavior that jeopardizes the safety or well-being of office personnel, provider(s) or other patients.

Please sign and date that you have read and understand our office policy.

Thank you.

_____	_____	_____
Print of Patient or Personal Representative	Relationship	Date
_____	_____	
Signature of Patient or Personal Representative	Date	
_____	_____	
Witness Signature	Date	