PLEASE PRINT

Patient Information

Name: ____

Last Name First Name Initial

Mailing Address: ____

City: ____________________ State: ______________ Zip Code: ______________

Home Phone: ______________ Sex: ☐M ☐F ☐Single ☐Married ☐Widowed ☐Divorced

Work Phone: ______________ S.S. #: ____________________ D.L. #: ______________

Patient's Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Student Birthdate: ______________

Patient Employed By: ______________________________ Occupation: ______________

Business Address: ____

In case of emergency who should be notified? ______________________ Phone: ______________

Primary Insurance (Policyholder Information)

Policyholder: ____

Last Name First Name Initial

Birthdate: ____________ Soc. Sec. #: ____________________ Drivers License #: ______________

Address: ____ Phone: ______________

City: ____________________ State: ______________ Zip Code: ______________

Policyholder's Employer: ______________________________ Occupation: ______________

Business Address: ______________________________ Business Phone: ______________

Insurance Company: ______________________________ Relationship to Patient: ______________

Group #: ____________________ Subscriber I.D. #: ______________________________

Secondary Insurance

Policyholder: ____

Last Name First Name Initial

Birthdate: ____________ Soc. Sec. #: ____________________ Drivers License #: ______________

Address: ____ Phone: ______________

City: ____________________ State: ______________ Zip Code: ______________

Policyholder's Employer: ______________________________ Occupation: ______________

Business Address: ______________________________ Business Phone: ______________

Insurance Company: ______________________________ Relationship to Patient: ______________

Group #: ____________________ Subscriber I.D. #: ______________________________

Authorization and Consent for Healthcare

I hereby authorize the physicians of ***Medic Lane Physicians, P.L.L.C.*** and affilated or other providers to release any informaton acquired in the course of my treatment, to release my insurance company, employer (for Workers Comp cases), or third party payer as required for claims filed, quality assurance, health plan administration, complaints/grievances. I understand that the specific information to be release may include, but is not limited to, history, diagnosis and/or treatment of drug and alcohol abuse, mental/psychiatric related illnesses or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I authorize direct payment to be made to ***Medic Lane Physicians P.L.L.C.*** or other providers for any and all medical and surgical services rendered. I understand if any services or charges are not covered, or if ***Medic Lane Physicians P.L.L.C.*** is unable to verify eligibility I will be financially responsible for all charges incurred for services rendered.

I hereby voluntarily consent to such healthcare encompassing diagnostic procedures and treatment by my physicians and my physician's associates, assistants and other healthcare providers, as may be necessary in my physician's judgement. I have relied on my physicians for information in the regard and acknowledge that no warranty or guarantee has been made to me. This form has been fully explained to me and I certify that I understand its contents.

____

Signature of Patient, Guardian or Responsible Party Date

Medic Lane Physicians P.L.L.C.
1100 Smith Drive
Alvin, Texas 77511

Patient: ______________________________ Employer: ______________________________

I.D. #: ______________________________ Group #: ______________________________

Assignment of Benefits

I hereby instruct and direct ______________________________ insurance company to pay by check made out and mailed to ***Medic Lane Physicians, P O Box 1968 Alvin, Texas 77512.*** If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows to ***C/O Medic Lane Physicians, P O Box 1968, Alvin, Texas 77512;*** for the professional or medical expense benefits allowed and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. ***This is a direct assignment of my rights and benefits under this policy.*** This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of the assignment shall be considered as effective and valid as the original.
- I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________________ Date: ______________________________
Signature of Policy Holder/Guarantor

Finanacial Policy

1. It is the patient's responsibility to provide current insurance information to the business office, If at any time your insurance information changes, you will be held responsible for any incorrect billing not filed within the time period limitations set by your insurance company.
2. The patient or guardian is responsible for your copay, deductible, coinsurance or any other out-of-pocket expenses.
3. The patient or guardian is responsible for all non-covered expenses.
4. The patient or guardian is responsible for all items deemed pre-existing by your insurance company.
5. The patient or guardian is responsible for all items your insurance carrier deems as "not medically necessary".
6. Some policies require that in the event of any emergency, the patient or guardian notify the insurance carrier within 24 to 48 hours or the following business day with details regarding the emergency. It is your responsibility to notify your insurance carrier. The business office will also notify the insurance carrier and try to obtain authorization.
7. If your insurance plan requires a referral, you are responsible for seeing that your PCP or Family Physician obtains a valid referral to this office. Otherwise the visit may not be authorized and you will be responsible for the charges, above your copay amount.
8. Once the billing office has billed for services provided to the patient, we allow the insurance company 90 days to pay or deny the claim. If payment is not received within the 90 days, you will be expected to pay the bill in full. If the bill cannot be paid in full, payment arrangements can be made through the billing office at (281) 331-0082.
9. The billing office will file your claim with the time limitation set by your insurance carrier.
10. Monthly statements will be sent to the guarantor with balances pending insurance payment and/or balances due by patient.
11. Patient's without insurance are required to pay all fees at the time of service.

I have read and fully understand the financial policy for ***Medic Lane Physicians P.L.L.C.***

______________________________ Date: ______________________________
Signature of Policy Holder/Guarantor

Patient Questionnaire

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

____

____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ***ONLY IN AN EMERGENCY*****:**

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____

III. Please print the address of where you would like your billing statements, lab results, referral information and/or correspondence from our office to be sent if other than your home.

____

____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked ***"CONFIDENTIAL"*****:**

YES ________ NO ________

V. Please print the telephone number, if any, where you want to recieve calls about your appointments, lab and x-ray results, referral information or other health care information if other than your home phone number: (   ) ____________________

VI. Can confidential messages (i.e.: appointment changes, lab results, referral information) be left on your home answering machine or voicemail?

YES ________ NO ________

VII. If you do not have voicemail, can a confidential message be left at your place of employment?

YES ________ NO ________

VIII. If you would prefer, we can notify you of your lab / diagnostic via your ***PERSONAL*** ***(not employment)*** email address: ____________________________________

I understand that it is ***MY RESPONSIBILITY*** to inform Medic Lane Physicians of any changes pertaining to my insurance information, address, telephone number, contact information and/or other information that may be released.

PATIENT NAME:__________________________________ (guardian if under 18 years)

____ __________________

PATIENT/GUARDIAN SIGNATURE DATE

MEDIC LANE PHYSICIANS NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDIC LANE PHYSICIANS uses health information about you for treatment to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of MEDIC LANE PHYSICIANS.

How MEDIC LANE PHYSICIANS May Use or Disclose Your Health Information

For Treatment, MEDIC LANE PHYSICIANS may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. The information may be released to: ANY SPECIALIST TO WHOM WE MAY REFER YOU.

For Payment. MEDIC LANE PHYSICIANS may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. MEDIC LANE PHYSICIANS may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- evaluate the performance of our staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the health care we provide.

Appointment. MEDIC LANE PHYSICIANS may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you with the following organizations: NONE.

Fund Raising. MEDIC LANE PHYSICIANS may use your information to contact your to raise funds for the following organizations: NONE.

Required by law. MEDIC LANE PHYSICIANS may use and disclose information about you as required by law.

For example, MEDIC LANE PHYSICIANS may disclose information for the following purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties;

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Health Information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research. MEDIC LANE PHYSICIANS may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research. The information may be released to: YOUR INSURANCE CO.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent MEDIC LANE PHYSICIANS has taken action in reliance on such.

Your Health Information Rights

Your have the right to:

- request a restriction on certain uses and disclosures or your information as provided by 45 C.F.R. §164.522; however, MEDIC LANE PHYSICIANS is not required to agree to a requested restriction;
- obtain a paper copy of the notice of information practices upon request;
- inspect and obtain a copy of your health record as provided for in 45 C.F.R. §164.524;
- request that your health record be amended as provided in 45 C.F.R. §164.526;
- request communications of your health information by alternative means or at alternative locations; and
- receive an accounting of disclosures made of your health information as provided by 45 C.F.R. §164.528.

Complaints

You may complain to MEDIC LANE PHYSICIANS and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations of MEDIC LANE PHYSICIANS

MEDIC LANE PHYSICIANS is required to:

- maintain the privacy of protected health information;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and

MEDIC LANE PHYSICIANS reserves the right to change its information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made available to you by mail.

Contact Information
If you have any questions or complaints, please contact:
MEDIC LANE PHYSICIANS
(PRIVACY OFFICER)
1100 SMITH DR.
ALVIN, TX 77511

MEDIC LANE PHYSICIANS, P.L.L.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________ , have received a copy of this office,s Notice pf Privacy Practices

____
Please Print Name

____
Signature

____
Date

____
For Office Use Only
____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

____

____

Name: ______________________________ Sex: M F Date of Birth: ____________

CURRENT MEDICATIONS (Including over the counter)

Medication	Strength	Times per day	Medication	Strength	Times per day

MEDICATION ALLERGIES

PAST MEDICAL HISTORY

Condition/Disease	Year Began	Condition/Disease	Year Began
□ Hypertension		□ GERD	
□ High Cholesterol		□ Depression or Anxiety	
□ Hypothyroid (low thyroid)		□ Heart Problems	
□ COPD, Emphysema or Asthma		□ Cancer (specify)	
□ Diabetes		Other(s):	

PAST SURGICAL PROCEDURES/HOSPITALIZATIONS

Operation/Hospitalization	Month/Year	Operation/Hospitalization	Month/Year

FAMILY HEALTH HISTORY

Relative	Living or Deceased	Current age or age at death	Cause of Death	Health Problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

SOCIAL HISTORY

Do you drink? □Yes □No	Number of drinks per week?	
Do you smoke? □Yes □No	If so, how many packs per day?	
Are you a former smoker? □Yes □No	If so, what year did you quit?	Number of years you smoked?

HEALTH MAINTENANCE

	DATE/LOCATION		DATE/LOCATION		DATE/LOCATION
Flu vaccine		Mammogram		Colonoscopy	
Pneumonia Vaccine		Pap Smear		Eye Exam	
Tetanus Vaccine		Bone Density		PFT	
Zostavax Vaccine				EKG	

OTHER PHYSICIANS AND SPECIALISTS (i.e., Gyn, Derm, Urologist)

Patient Signature: ______________________________ Today's Date: __________