Valley Baptist Physician Network

VALLEY BAPTIST PHYSICIAN NETWORK

New Patient Registration Form

PATIENT INFORMATION: **TODAY'S DATE:** ___ / ___ / _____

Last Name: _____ **First Name**: _____ **Middle Initial**: _____

Preferred Name: _____ **Former Last Name**: _____

Sex: ____Male ____Female **Date of Birth**: _____ **SS#:** _____ - _____ - _____

Street Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

Home Phone: _____ **Mobile Phone**: _____ **Work Phone**: _____

Email: _____ **Contact Preference**: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

Preferred Language: English Spanish Other: _____ **Race:** (Arab) (Asian) (Black or African American) (Other Race) (White) (Other)

Ethnicity: (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Not Hispanic or Latino) (Mexican) (Puerto Rican) (Central American)

Other: _____

Marital Status: _____ **Referring Provider**: _____ **Patient PCP**: _____

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Community Event) (Website) (Friend/Family) (Employer)

(Other _____)

INSURANCE INFORMATION:

Primary Insurance: Plan Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

Secondary Insurance: Plan Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

EMPLOYER INFORMATION: Employer Name: _____ Employer Phone: _____ Occupation:_____

CLINICAL INFORMATION: Preferred Pharmacy: _____Phone: _____

Preferred Laboratory: _____

GUARDIAN INFORMATION: Guardian Last Name: _____ Guardian First Name: _____

EMERGENCY CONTACT INFORMATION: Last Name:_____ First Name:_____ Phone:_____ Relationship:_____

Signature of Patient:_____**Date:**_____

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Clinic Information

We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. We do not give one year prescription refills. The practice is closed on weekends and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request.

____ **PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or other applicable forms, there may be a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes may require appointment rescheduling.

____ **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

____ **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hours' notice. If you fail to notify us and miss your appointment, there may be a $25 fee and possible termination from the office if excessive. There may also be a fee of $25 if you cancel your appointment on the same day.

____ **LAB & RADIOLOGY RESULTS:** Once reports are received, the physician will review the results and have our clinical staff contact you within 10 business days.

____ **Office Visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require multiple visits.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

_____ _____ _____

Patient Signature **Printed Name** **Date**

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Notice Of Privacy Practices (NPP) Acknowledgement

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize VALLEY BAPTIST PHYSICIAN NETORK (VBPN) to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to VBPN any information obtained in the adjudication of any claim for services furnished to me by VBPN.
- I acknowledge that VBPN, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____

Date: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize VBPN to (check all that apply):Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name*:* _____ Relationship to Patient:_____

Name*:* _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ Date: _____

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Consent to Contact

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

*Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact

Name: _____ Relationship to Patient: _____

Signature: _____ Date:_____

VALLEY BAPTIST PHYSICIAN NETWORK

Financial Policy and Authorizations

We are happy that you selected VALLEY BAPTIST PHYSICIAN NETWORK for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.
Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.
Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.
Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.
HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.
Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.
Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.
Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.
Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.
Authorizations and Consent
ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.
ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.
CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.
NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.
I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____ _____

Patient or Parent/Guardian if Minor Date 2-23-2007; Rev 2-13-15; Rev 8-1-15 VALLEY BAPTIST PHYSICIAN NETWORK

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VALLEY BAPTIST PHYSICIAN NETWORK

New Patient Questionnaire

Patient Name: _____ Date of Birth: _____

CURRENT MEDICAL PROBLEM

What problem brought you here? _____

What symptoms are you having? _____

When did the symptoms begin? _____

Has your appetite changed in the last six months? Increased Decreased Stayed the same

Has your weight changed in the last six months? No Yes: Gained _____ lbs Lost _____ lbs

Has your overall energy level changed? Increased Decreased Stayed the same

ALLERGIES

Are you allergic to any medications, pills, food, etc.?

Drug/ Allergen	Reactions?	Onset Date:

MEDICATIONS

Please list all medications or pills that you take, that you do not utilize your insurance to obtain or that are not prescribed by a physician. Please include all vitamins, herbal supplements, and/or over the counter medications.

Medicine or pill name	Dose (e.g., 50 mg)	How many times per day?	Why do you take this?

VACCINATIONS

Have you received a pneumonia vaccine with the past 5 years? No Yes, date _____ Don't know

Have you received a flu vaccine this season? No Yes, date _____ Don't know

When was your last tetanus? Date: _____ Don't know

PAST MEDICAL / SURGICAL HISTORY

Please circle Yes or No to any medical problems.

Anemia Y / N
Anxiety Y / N
Arthritis and/or Gout Y / N
Asthma Y / N
Bleeding Problems Y / N
CAD Y / N
CHF Y / N
Cancer (If yes, specify type) Y / N
Convulsions/Seizures Y / N
Dental/Oral Problems Y / N
Depression Y / N
Diabetes Y / N
Gastritis/Ulcer Y / N
HIV/AIDS Y / N
Headaches/Migraine Y / N
Hepatitis Y / N
High Blood Pressure Y / N
High Cholesterol Y / N
Kidney Disease/Stones Y / N
Overweight/Obesity Y / N
Pneumonia Y / N
Sexually Transmitted Disease Y / N
Stroke Y / N
Thyroid Disease Y / N
Tuberculosis (or positive Tb test) Y / N

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New Patient Questionnaire

SURGICAL HISTORY
Please list any previous operations or procedures:

Procedure / Operation	Date	Surgeon	Hospital

FAMILY HISTORY

Relation:	Problem: Ex: Stroke, Heart Disease, Diabetes, Hypertension, etc.,	Onset Age	Died of Age	Notes

SOCIAL HISTORY:
Please circle or complete the most applicable.

Smoking Status: Never Smoker/ Former Smoker/ Current every day smoker
If so, Has smoked since age: _____
If so, How much: None/ 1 PPW /2 PPW/ 1/4 PPD/ 1/2 PPD/ 1 PPD 1 1/2 PPD/ 2 PPD/ 3+ PPD
Chewing tobacco : None/ 1 day/ 2-4 day/ 5+/day
Exercise level: None/ Occasional/ Moderate/ Heavy
Diet: Regular/ Vegetarian/ Vegan/ Gluten free Specific / Carbohydrate

General Stress Level: Low/ Medium/ High
Alcohol intake : None/ Occasional/ Moderate/ Heavy
Caffeine intake: None/ Occasional/ Moderate/ Heavy
Illicit drugs : _____
Sunscreen used routinely: Y/ N
Does anyone living in your home smoke? Yes/ No

GYN HISTORY
Number of pregnancies: _____
Number of miscarriages: _____
Age at Menarche: _____
Duration of Flow (days) : _____
Menses Monthly: Yes/ No

Number of live births: _____
Number of abortions: _____
If Post-Menopausal, Age at Menopause: _____
LMP: Unknown / Approximate/ Definite

Current Birth Control Method: BCPs/ UD/ Diaphragm/ Tubal Ligation/ Partner Vasectomy/ Depo-Provera/ Condoms/ None
Hormone replacement: Yes/ No

QUALITY METRICS

Test or Measure	Date Last Completed	Physician/Location Performed By
Colonoscopy (all patients 50-75)		
Mammogram (female patients 40-69)		
Cervical Cancer Screening/ PAP (female patients 21-64, every 3 years)		
Pneumonia Vaccine (patients 65 and older)		

I understand that Quality Measures are ordered by my doctor to aid in prevention and diagnosis. I understand that by not having these measures done, I am going against the medical advice of my doctor.

Valley Baptist Physician Network

Review of Systems

Name: _____ **Date of Birth:** _____

Pt Height: _____ **Tobacco Use:** **Present**_____ **Past**_____ **Never** _____

Circle any symptoms you have experienced in the past few months.

General - Fever Chills Sweats Anorexia Fatigue Vomiting Weakness Physical discomfort Nausea Weight loss Sleeping Problems

Eyes - Blurred Vision Double vision Eye Irritation Discharge from Eyes Vision loss Eye pain Sensitivity to light

Ears/Nose/Mouth/Throat - Ear ache Ear discharge Abnormal sound in ears Decreased hearing Nasal congestion Nosebleeds Sore Throat Hoarseness Ringing in ears Difficulty swallowing

Cardiovascular - Chest pains Palpitations Dizzy/Faint High Blood Pressure Heart murmur Heart failure Irregular heartbeat Light headedness Shortness of breath

Respiratory - Cough Difficulty breathing Excessive phlegm Coughing blood Wheezing

Gastroenterology - Nausea Vomiting Diarrhea Constipation Change in bowel habits Abdominal pain Black/dark stools Bloody stools Yellowish skin or eyes Gas/bloating Indigestion/heart Difficulty swallowing Painful swallowing

Muscular Skeletal - Back pain Joint pain Joint swelling Muscle cramps Muscle weakness Stiffness Arthritis Sciatica/leg pain Restless legs Leg pain at night Leg pain with activity

Neurology - Paralysis/Loss of the ability to move a body part Abnormal sensation to skin Seizures Tremors Dizziness Sudden vision loss Frequent falls Frequent headaches Difficulty walking Headaches

Behavioral Health - Depression Anxiety Memory loss Suicidal thoughts Hallucinations Panic attacks Paranoia(Anxiety/Fear) Phobia(Fear of things) Confusion

GU-Female - Vaginal discharge Involuntary urination Painful urination Blood in urine Urinary frequency Absence of menstrual period Heavy menstrual period Abnormal vaginal bleed Pelvic pain Genital sores Decreased sexual desire

GU-Male - Painful urination Blood in urine Penile discharge Urinary frequency Urinary hesitancy Frequent urination at night Involuntary urination Genital sores Decreased sexual desire Inability to have an erection

Valley Baptist Physician Network

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____
Last First Middle

Home Address:_____

_____

Home Telephone:_____ Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report
☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report
☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record
☐ Other_____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom VALLEY BAPTIST PHYSICIAN NETWORK may disclose my health information: _____

Address of the recipient or where my health information should be delivered:_____

_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20____.

☐ Until VALLEY BAPTIST PHYSICIAN NETWORK fulfills this request.

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE: I authorize VALLEY BAPTIST PHYSICIAN NETWORK to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] _____

_____

_____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once VALLEY BAPTIST PHYSICIAN NETWORK discloses my health information to the recipient, VALLEY BAPTIST PHYSICIAN NETWORK cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that VALLEY BAPTIST PHYSICIAN NETWORK may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at VALLEY BAPTIST PHYSICIAN NETWORK; except, however, if my treatment at VALLEY BAPTIST PHYSICIAN NETWORK is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case VALLEY BAPTIST PHYSICIAN NETWORK may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to VALLEY BAPTIST PHYSICIAN NETWORK Privacy Office at the address listed below. The revocation will be effective immediately upon VALLEY BAPTIST PHYSICIAN NETWORK receipt of my written notice, except that the revocation will not have any effect on any action taken by VALLEY BAPTIST PHYSICIAN NETWORK in reliance on this Authorization before it received my written notice of revocation.

I may contact VALLEY BAPTIST PHYSICIAN NETWORK Privacy Office by mail at:

_____ or by e-mail at HHH-Privacy@TenetHealth.com.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize VALLEY BAPTIST PHYSICIAN NETWORK to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____	_____	_____
Signature of Authorized Personal Representative	Relationship to Patient	Date

RGV WOMEN'S HEALTH CENTER
2230 Haine Dr.
Harlingen, TX 78550