James R. Bond, Jr., M.D., P.A.
1615 Lancaster Dr., Suite 107
Grapevine, TX 76051
(817)488-5555 Fax: 817-421-0400

PATIENT REGISTRATION

Please fill in all blanks. If not applicable, please write N/A in that space. Thank you!

Name: _____

Address: _____

City/State/Zip: _____

Date of Birth: _____ Age: _____ Sex: Male / Female

Social Security #: _____Home Phone: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Employer: _____

Referring or Primary Care Physician: Name/Address/Phone #:

_____

Race (select one):
White
Black or African American
Asian
Native Hawaiian or Other Pacific Islander
American Indian or Alaska Native

Other Race: _____

Ethnicity (select one): Hispanic or Latino
Not Hispanic or Latino

Insurance Name and Address:

_____

ID Number: _____ Group: _____

Guarantor Information *(Responsible Party and/or insurance subscriber) if same put N/A*

Name _____

Address/City/State/Zip: _____

Social Security #:_____ Date of Birth: _____

Home #: _____Cell#: _____ Sex: Male / Female

Email: _____Relationship: _____

Employer: _____

I, _____, authorize this facility to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialist providers which are assigned to me according to my insurance policy rule. It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians and hospitals. We will call, fax or e-scribe the pharmacy of your choice regarding prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

_____ _____

Patient or Responsible Party Signature Date

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To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held in your password protected file until your insurances have paid their portion and notified us of the amount of your share. At the time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be either mailed or emailed to you.

This will be an advantage to you, since you will no longer have to mail us checks or call in to make payment over the phone. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely yours,

I authorize James R. Bond, Jr., M.D., P.A. to charge outstanding balances on my account to the following credit card. This will be kept on file and updated yearly.

Visa MasterCard American Express Discover

Account #:_____

Expiration Date: _____ CVV: _____

Name on card(please print): _____

Signature: _____ Date: _____

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Disclosure of Medical/Financial Information to Friends or Family
(For Patients 18 years and older)

Name of Patient: _____

Date of Birth: _____ Phone Number: _____

Email: _____

I, the undersigned, hereby authorize Dr. James R. Bond, Jr. and staff to disclose information from my medical or financial record to the following people:

Name: _____ Relationship: _____

Phone Number: _____

Type of information (circle): Medical Financial Both

_____

Name: _____Relationship: _____

Phone Number: _____

Type of Information (circle): Medical Financial Both

This authorization is given freely with the understanding that:

1. This authorization is valid between January through December of year signed.
2. May revoked in writing at any time but not retroactively.
3. The facility, its employees, officers, and physician are hereby released from any legal responsibility of liability for disclosure of the information I authorized previously.

_____ _____

Patient Signature or Authorized Representative Date

James R. Bond, Jr., M.D., P.A.
1615 Lancaster Dr., Suite 107
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Patient Consent for Use and Disclosure Of Protected Health Information

With my consent, James R. Bond, Jr., M.D., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to James R. Bond, Jr., M.D., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been provided with a copy of the Notice of Privacy Practices prior to signing this consent. James R. Bond, Jr., M.D., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Marisela Acosta, Privacy Officer at 1615 Lancaster Drive, Suite 107, Grapevine, TX 76051.

With my consent, the office of James R. Bond, Jr., M.D., P.A. may call my home or other designated 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 call pertaining to my clinical care, including laboratory results among others.

With my consent, the office of James R. Bond, Jr., M.D., P.A. may mail to my home or other designated 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 my consent, the office of James R. Bond, Jr., M.D., P.A. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of James R. Bond, Jr., M.D., P.A. restrict how it uses or discloses my PHI to carry out TPO. However, 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 give the office of James R. Bond, Jr., M.D., P.A. use and disclosure of 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 my prior consent. If I do not sign this consent, the office of James R. Bond, Jr., M.D., P.A. may decline to provide treatment to me.

_____ _____

Print Patient's Name Date

_____

Signature of Patient or Legal Guardian

James R. Bond, Jr., M.D., P.A
1615 Lancaster Dr., Suite 107
Grapevine, TX 76051
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HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness .....

Printed Name of Individual or Legal Representative .....

Witness.....

Date: .....

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____

Marisela Acosta-Office Manager
HIPAA Officer

_____
Date

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*******FOR ALL OUR PATIENTS 65 YEARS OLD AND OLDER*******

Name: _____

Address: _____

Phone #: _____ DOB: _____

Email: _____

Have you received the pneumonia vaccine? Yes No

Have you received the flu vaccine in the last year? Yes No

Do you have a living will? Yes No

Which statement best reflects your wishes on advanced care recommendations?

_____Do Not Intubate: I do not wish to have a breathing tube even if it is necessary to save my life.

_____Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

_____Full Cardiopulmonary Resuscitation. I want full cardiopulmonary resuscitation efforts to be made.

Primary Care Doctor or Family Doctor: **(Please provide name and phone #)**

_____

Who in your family or household can make medical decisions in case of an emergency? Please give name and phone number:

_____

_____ _____

Signature Date

Updated 6-22-22

Name: _____ _____DOB:_____Date:_____

Are you allergic to, or have you had a reaction to any drugs? If so, please list with reaction(Ex: Penicillin-Rash):

_____

Please list your ***personal*** medical history here. Please do not list ***family*** history here:

Yes	No	
		History of skin cancer? If yes, list location, year and type: Basal Cell, Squamous Cell, Melanoma.
		History of other cancers: Lung, Breast, Prostate, Etc.
		History of Acne?
		History of Keloids or Large Scars?
		History of Eczema or Dermatitis?
		History of Psoriasis?
		History of Hair Disorders? Please specify.
		History of Nail Disorders?
		Lung problems: Emphysema, tuberculosis, asthma, or other?
		Endocrine problems? Diabetes, Thyroid, Etc.
		Heart, Blood Pressure or Circulation problems? List type.
		Do you have a Pacemaker?
		Stomach or Intestinal problems? Specify.
		Arthritis, bone or muscle problems? Specify.
		Psychiatric: Depression, Bipolar disorder, Schizophrenia, or other? Specify.
		Neurologic: Seizures, Stroke, MS, or other? Specify.
		Autoimmune diseases: Lupus, Rheumatoid Arthritis, Scleroderma, or other? Specify.
		Eye, ear, nose, or throat problems? Specify.
		Kidney, bladder, prostate or female organ disorder? Specify.
		Anemia, leukemia, or blood diseases? Specify
		Are you pregnant?
		Are you planning a pregnancy?
		Illicit Drug Use?

Cigarette Smoking: Never Smoke Former Smoker Smoke Daily: How much?_____

Chewing Tobacco: Never Former Current: How much? _____

Sexual History: Not active Active with one partner Active with more than one partner Same sex partner

Alcohol Use: None Less than 1 drink a day 1-2 drinks a day 3 or more a day

Is there a ***family*** history of any of the above conditions? (***List immediate family only: mother/father/brother/sister)***

_____

Please list only the names of medications you are currently taking:

_____

_____

History Form Page Two:

Name:_____ DOB:_____ Date:_____

Please circle past surgeries:

Appendix Removed

Bladder Removed

Breast Implants

Coronary Artery Bypass

Heart Transplant

Kidney Removed: (right or left)

Kidney Transplant

Mastectomy (right left bilateral)

Prostate Biopsy

Skin Biopsy

Testicles Removed: (right left bilateral)

Angioplasty of Heart

Breast Biopsy (right left bilateral)

Breast Reduction

Gallbladder Removed

Kidney Biopsy

Kidney Stone Removal

Lumpectomy (right left bilateral)

Mechanical/Biological Valve Replacement

Prostate Removed due to Prostate Cancer

Spleen Removed

TURP

Colectomy:
Colon Cancer Resection Diverticulitis Inflammatory Bowel Disease

Hysterectomy due to:
Fibroids Uterine Cancer Other:_____

Joint Replacement: Knee (right left bilateral)

Hip (right left bilateral)

Ovaries Removed due to:

Endometriosis Cyst Ovarian Cancer

Skin Surgery: Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

N/A to above conditions

Other Surgeries not listed:_____

Financial Policy
Medicare Part B

Thank you for choosing our practice. We want to make every experience you have with us a positive one. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel we can no longer assume that patients fully understand the relationship between the insurance company, the doctor, and themselves. In an effort to clarify this relationship, we have developed a set of guidelines regarding financial responsibility. If you have any questions, please speak with the office staff. You will be asked to sign at the end of the form.

·**As a participating provider, we accept assignment of benefits and file all Medicare claims for you.**
Please be aware that Medicare does not pay us the total charges allowed at the time of your visit. You will be responsible for 20% of the total charges at each visit. Furthermore, each calendar year you begin a new deductible with Medicare. If your deductible has not been met for the year, we will ask for payment up to your deductible amount at the time of your visit.

·**Medigap.**
If your secondary insurance plan is part of Medigap (sent electronically by Medicare), your signature will allow us to file claims and assigns to this office all rights, title and interest to your medical reimbursement benefits under your insurance policy.

·**Medicare sets the fees that we may charge.**
Any procedures not covered by Medicare (see below) will be identified at the time of service. Medicare does not set the fees for services that are "not medically necessary" and you will be asked to pay for these procedures at the time of service.

·**Not Medically Necessary or Cosmetic Procedures.**
In order to keep health care costs down, Medicare has put restrictions on some previously covered procedures. Our office is aware of many of these not medically necessary or cosmetic procedures and will attempt to alert you to these procedures when possible. If you and the doctor decide to continue with a procedure that falls into this category, we require payment in full at the time of service. There is no reduction in fees for Medicare patients when cosmetic procedures are performed.

·**The following procedures are routinely considered not medically necessary or cosmetic:**
Medicare may not cover these services (including office visits for evaluation of these conditions):

-Removal of benign lesions (moles, warts ,skin tags, cherry or spider angiomas, lentigos or liver spots, cysts, milia and seborrheic keratoses)
-Collagen treatments
-Glycolic acid or other chemical peels
-Ear piercing
-Scar revision
-Laser surgery for certain benign lesions
-Cautery for treatment of dilated blood vessels on the face
-All forms of Hair Loss
-Vitiligo
-Acne surgery

·**Laboratory and Pathology Fees.**
Many times it is necessary to obtain tissue or perform lab tests to confirm a diagnosis or to determine a course of treatment. If any tissue is removed for a pathology examination or if a laboratory test (blood

work, culture, etc.) is done in our office, the actual test is usually carried out by someone else. The lab is required to bill with Medicare for their services. You will receive a bill from the lab after Medicare has paid, and you may be required to pay a percentage of that bill.

If you receive a bill from a lab, please contact that lab directly to resolve any billing concerns.

·**Forms of Payment.**

For your convenience, we accept cash, personal checks, Mastercard and Visa.

·**Estimation of Services.**

We will be happy to give you an estimate of fees when this is possible. Please, remember that only the doctor can give you an accurate estimation of the cost of a procedure since he will determine the exact procedure to be performed. We can only assure you of the exact cost of a procedure on the day of service when the doctor has determined the actual coding to be used. The estimate of our charges will not include work done by any outside lab or pathology service.

·**Returned Checks.**

There is a fee of **$40.00** for all returned checks.

·**Collection Efforts.**

We will send you **FOUR** statements regarding ***your*** balance. On the **THIRD** statement a **1.5%** service charge will be added to ***your*** balance. If you should receive a **FOURTH** statement noted ***"Final"*** the account balance will be turned over to a collection agency. We will add a **35% transaction fee** to any outstanding balance that is turned over to a collection agency. All fees charged are ***your*** responsibility.

Please recognize that the practice of medicine is not an exact science and acknowledge that there are no guarantees or assurances concerning the results of procedures.

By signing below, I am indicating that I do not have a government plan such as ***MEDICAID*** or ***CHIPS*** or ***STAR***.

I have read and understand the above completely and agree to comply with the financial policies of this office. My signature authorizes this office to file my claims and assigns to this office all rights, title and interest to my medical reimbursement benefits under my insurance policy.

I understand that my signature also allows this office to release information regarding my visits to my insurance carrier. **I understand that I am responsible for my bills in the event the insurance company denies any claims.**

_____ _____

Signature of Patient (or Power of Attorney) Date