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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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
Grapevine, TX 76051
817-488-5555 Fax: 817-421-0400

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
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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

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:_____

-Cautery for treatment of dilated blood vessels on the face
-Hair Loss
-Vitiligo

·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.

THIS MEANS YOU WILL RECEIVE A SEPARATE BILL FROM ANOTHER DOCTOR OR LAB FOR THESE TESTS.

·Forms of Payment.

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. Please keep in mind that it is only an estimate of costs. Unforeseen circumstances could cause the actual cost of a procedure to increase when done at a later date. The only time we can assure you of the exact cost of a procedure is on the day of service when the doctor has determined the actual coding to be used. Also, please remember that 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. There will be a **35%** service charge to any outstanding balance that is turned over to a collection agency. All fees charged are your responsibility.

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

I have read and understand the above completely and agree to comply with the financial policies of this office. I understand that my signature also allows this office to release information regarding my visits to my insurance carrier should they request additional information about a claim that I file.

_____ _____

Signature of Patient (or Parent, if patient is a minor) Date

Financial Policy
Fee for Service, Private or General Insurance

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.

·Payment is expected at the time of service.

We will give you the necessary forms for submission to your insurance carrier for a partial reimbursement of fees incurred. The amount reimbursed by your carrier may be adjusted, according to your plan provisions.

·Determining Our Charges.

An office visit charge includes discussing your complaints with the doctor, your examination and assessment, and any treatment given by prescription. Many times patients are unaware that when procedures are performed in the office they are not necessarily included in the charge for the office visit. Procedure charges would include such things as performing a biopsy, removing or destroying a skin lesion, performing cosmetic procedures (see below), or drawing blood for a laboratory test. Please be aware that if a procedure is done during an office visit, this may add to the total cost of your visit. If you have any questions about our charges, please ask us **before** we perform a procedure. We do not generally discuss costs of procedures unless you ask.

If you have no insurance and feel like you cannot afford a procedure you need, please let us know. We will do whatever we can to help someone who needs care but has an inability to pay at the time services are rendered.

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.

·Not Medically Necessary or Cosmetic Procedures.

The following procedures are routinely considered not medically necessary or cosmetic. Your insurance carrier may not reimburse you for 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