Prima Health Clinic
8345 Walnut Hill Lane, Suite 105
Dallas, TX 75231

REGISTRATION FORM

(English Form)

PATIENT INFORMATION

Patient's Name: _____ **Date of Birth:** _____ **Social Security No:** _____

Gender: Male Female **Marital Status:** Single Married Divorced Separate Widow

Address: _____ **Apt No.:** _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone No.: _____ Home Cell Phone Work

Secondary Phone No.: _____ Home Cell Phone Work

INSURANCE INFORMATION

Please check all that apply: Medicaid CHIP Medicare PPO HMO Selfpay

Primary Insurance

Medicaid/CHIP: _____ Medicare: _____

Member ID: _____ Group No.: _____

Primary Card Holder: _____

Date of Birth: _____

Social Security No.: _____

Phone No.: _____

Relationship to patient: Self Spouse Guardian

Secondary Insurance

Medicaid/CHIP: _____ Medicare: _____

Member ID: _____ Group No.: _____

Primary Card Holder: _____

Date of Birth: _____

Social Security No.: _____

Phone No.: _____

Relationship to patient: Self Spouse Guardian

MEDICAID DISCLOSURE AGREEMENT

The purpose of this agreement is to prevent any misunderstandings and provide efficient care and coverage for you.

If you are covered by another insurance or health plan other than your respective Medicaid plan, you are required to disclose this information to **PRIMA HEALTH CLINIC** at the time of your visit.

If you are covered by another insurance of health plan other than your respective Medicaid plan, you are required to provide full disclose of this information to **MEDICAID**. This is your legal obligation.

Failure to provide disclosure of other insurance or health plan coverage will result in delay in processing or denial of your Medicaid claim. We reserve the right to deny services if you fail to comply.

Furthermore, if you fail to provide other (ALL) insurance or health plan coverage information at the time of your visit and your claim is denied by Medicaid for such reasons, you will be held responsible for reimbursement of all medical services incurred on the date of service.

_____ I will have disclosed all insurance, health plan and/or Medicaid information to each insuring party prior to my visit.

_____ I will provide **PRIMA HEALTH CLINIC** with ALL insurance, health plan and/or Medicaid information at the time of my visit.

_____ I will provide proof of current Medicaid eligibility for the current period at the time of my visit.

_____ I understand that failure to provide adequate proof of insurance and/or Medicaid coverage at the time of my visit may result in denial of services.

_____ I will accept full responsibility for reimbursement of services rendered if my Medicaid claim is subsequently denied for failure to disclose other insurance and/or health plan information.

_____ I agree to all terms and provisions described above.

HIPAA DISCLOSURE

Our office, **PRIMA HEALTH CLINIC**, will send your claims for services performed by us directly to your insurance company. However, you are responsible for any charges that are not covered by the insurance due to the following reason(s):

- No insurance coverage.
- Insurance terminated.
- The charges applied to the deductible.
- Insurance needs additional information from the insured.
- Insurance is not covering the charges because of pre-existing conditions.
- The effective date of coverage was after the date of service.
- Your primary care physician is not one of our doctors at Prima Health Clinic, and you have not changed prior to the date of service.
- The treating doctor is not a participating provider of your insurance.
- The services render were not medically necessary determined by your insurance.
- Labs and some procedures are not covered under your insurance plan.
- Invalid identification number. We need your insurance card.

Attention Patients: Our office, Prima Health Clinic, is not responsible for the charged billed to you from the hospitals, outside lab and/or any other services out of our office.

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At **PRIMA HEALTH CLINIC**, we are committed to treating and using protected health information about your responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describe your rights as they relate to your protected health information. This notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD / HEALTH INFORMATION

Each time you **PRIMA HEALTH CLINIC** a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another pay (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding that is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

PRIMA HEALTH CLINIC is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/or locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of **PRIMA HEALTH CLINIC**. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgement when disclosing health information to a family member, other relatives, or any other person that is involved in your case or that you have authorized to receive this information. Please inform the practice when you do not wish a family member of other individual to have authorization to receive your information.

Research / Teaching / Training. We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or, a brief, non-specific message may be left on your answering machine. If you don't approve of this methods, or, if you prefer alternative methods (i.e. Email) please inform the practice.

Other uses and disclosure. Disclose of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of **PRIMA HEALTH CLINIC**, please contact our office.

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

WAIVER OF PRIVACY

I, _____, of sound state and mind, do hereby give permission to **PRIMA HEALTH CLINIC** to view and discuss my private health information which may include by is not excluded to: medical records, laboratory results, diagnostic imaging results, financial records, and physician's state and recommendations with the following person(s):

_____ who is my _____
(NAME OF PERSON) (RELATION TO PATIENT)

_____ who is my _____
(NAME OF PERSON) (RELATION TO PATIENT)

My consent of full disclosure of my personal and private medical information to the above named person(s) will expire when I present written and/or verbal notification to **PRIMA HEALTH CLINIC**.

The above information is true to the best of my knowledge, I authorized my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **PRIMA HEALTH CLINIC** or insurance company to release any information required to process my claims.

_____ _____
Signature Date