PATIENT REGISTRATION FORM

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail
Marital Status	Gender

EMERGENCY CONTACT INFORMATION

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

HIPPA RELEASE INFORMATION

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

Printed Name of Emergency Contact (first, middle, last name)
Relationship to Patient (Parent, Child, Spouse, Other- Please Specify)
Phone Number

FINANCIAL RESPONSIBILITY AGREEMENT

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

I understand and agree to pay the co-pay or patient due balances before being seen by the physician.

Initial	I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam, physical, lab testing, x-ray, EKG and any other screening service or diagnostic testing ordered by the physician or the physicians' staff.
Initial	I understand and agree it is my responsibility and not the responsibility of the physician or clinic to know if my insurance will pay for my medical service or visit. For preventative or physical exams, lab testing, x-ray, EKG, or any other screening service or diagnostic testing ordered by the physician or the physicians' staff.
Initial	I understand and agree is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amount, usual and customary limit, or any other type of benefit limitation for the services I receive and I agree to make full payment.
Initial	I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
Initial	I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
Initial	I understand that I will be receiving a bill from BEST WAY CLINIC OF BURLESON for any and all balances due to be billed on behalf of BEST WAY CLINIC OF BURLESON.
Initial	***I understand that my behavior in the clinic must be courteous and respectful. That I will not cause any disturbance and/or raise my voice to any staff member. I understand that the Clinic reserves her right to discharge me if this line of the contract if violated, therefore I will have to find another primary care physician.***

Printed Name of Patient or Personal Representative (first, middle, last name)	
Signature of Patient or Personal Representative	Date Signed

CODE OF CONDUCT AGREEMENT

Initial

I understand that my behavior in the clinic must be courteous and respectful. That I will not cause any disturbance and/or raise my voice to any staff member. I understand that the Clinic reserves the right to discharge me if this line of the contract is violated, therefore I will have to find another primary care physician.

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release all health information about me.

The following person/organization is hereby authorized to receive my entire medical record, treatment record and diagnostic record to the following person or organization: **Best Way Clinic of Burleson, 12300 Bear Plaza suite 408, Burleson, TX 76028.**

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

Entire Medical Record including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers. Patient Histories, Office Notes (except psychotherapy notes) Test Results, Radiology Studies, Films, Referrals, Consults, Billing Records, Insurance Records, Records Sent by Other Health Care Providers, Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis, HIV-Related Treatment, Mental Health Information or Psychological Conditions, Alcohol or Substance Abuse Treatment and Genetic Testing

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for as long as I am become patient at the facility, following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Patient or legal representative signature: _____ **Date:** _____

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different site.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Best Way Clinic of Burleson at 817-585-1768
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____	_____
Patient Name	Patient Signature	Date

NO Call / NO Show

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your Schedule appointment time.

If an appointment is not cancelled or patient fails to show up for appointment, Best Way Clinic of Burleson reserves the right to charge patient a $25 Fee per occurrence. As this fee is not billed to any insurance company, patient accepts full responsibility to pay this fee.

If you have any questions about this form, please talk to us before signing.

Thank you

Patient's Name: _____

Patient Signature: _____

Date: _____

Consent to Treat Form

1. I _____ (patient name) give permission for Best Way Clinic of Burleson to give me medical treatment.

2. I allow Best Way Clinic of Burleson to file for insurance benefits to pay for the care I receive.

I understand that:

- Best Way Clinic of Burleson will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

Patient Signature: _____

Parent or Guardian Signature (for children under 18): _____

Date: _____

Patient Email Privacy Consent Policy

To better serve our patients, this office has established an email address for some forms of communications. This means of communication is used by our clinic to send you, requested documentation. Our email is not constantly monitor therefore remember, that this form of communication is not appropriate for use in an emergency.

We will use this type of communication for to send you requested billing and medical records only.

This office is dedicated to keeping your medical record information confidential. Our clinic emails are encrypted, which gives a layer of security to the messages, but despite our best efforts, if your email is not encrypted, there is a risk that third parties may have access to messages.

When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to a particular person in our clinic other colleagues would have access to this information, and will be kept confidentially according to HIPPA laws.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control. I understand and agree to the above e-mail policy.

_____ _____

Patient name and signature Witness (optional)

_____ _____

Date Date

Advanced Practice Nurse
Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical care.

An Advanced Practice Nurse is not a Medical Doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. In Texas, as delegated by a physician, an advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

_____ _____

Patient's Name/Date of Birth Patient's signature

_____

Today's date

THE EPWORTH SLEEPINESS SCALE

Patient's name: _____ DOB: _____ Sex: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. Use the following scale to circle the most appropriate number for each situation:

0 = would never doze or fall asleep

1 = slight chance of dozing or falling asleep

2 = moderate chance of dozing or falling asleep

3 = high chance of dozing or falling asleep

SITUATION	*CHANCE OF DOZING*
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater, a meeting, or a park)	
As passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstance permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Patient Signature: _____

Date: _____