ACTON MEDICAL CLINIC

REGISTRATION FORM

(Please Print)

2021

PATIENT INFORMATION

Patient's last name:	First:	MI:	
Marital status (circle one) Single / Married / Divorced / Separated / Widowed	Birth date:	Social Security no.:	Sex: ☐ M ☐ F
Patient address:	Cell Phone no.:	Home phone no.:	
City:	State:	Zip Code:	Drivers License no.:
Relationship to person responsible for bill: ☐ Self ☐ Spouse ☐ Child ☐ Other ____	EMAIL:		
Occupation:	Employer: Employer Address:	Employer phone no.:	
Chose clinic because/Referred to clinic by (please check one box): ☐ Family ☐ Friend ☐ Yellow Pages ☐ Hospital ☐ Internet ☐ Insurance ☐ Other ____			

PERSON RESPONSIBLE FOR BILL

Same As Patient : ☐ yes ☐ no If yes, skip this section

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:
Subscriber's name:		Subscriber's S.S. no.:	Birth date:

INSURANCE INFORMATION

Primary Insurance:

Secondary Insurance:

IN CASE OF EMERGENCY

Name of emergency contact:	Relationship to patient:	Phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Acton medical clinic or insurance company to release any information required to process my claims.

_______________________________ _______________

Patient/Guardian signature *Date*

ACTON MEDICAL CLINIC

Effective November 1, 2002, patients will ultimately be responsible for all legitimate charges that are denied by insurance. All claims from this clinic will be filed in a timely manner and will be filled accurately. If your insurance denies payment or delays payment beyond 90 days for frivolous reason, the patient will be responsible for that expense.

Acton Medical Clinic sincerely regrets that we must take this course of action; however, as you will know insurance dominates reimbursement in the medical industry. Current law is influenced by the insurance industry such that payment of fees is withheld by insurance for up to 90 days with no consideration of punitive consequences by law. After this period, they can continue to hold compensation for legitimate services if they so choose. This has put a tremendous burden on doctors and other health services. Consequently, you the patient, the insured, suffers as well as the provider of medical services.

____________________________ ____________________

Patient Date

ACTON MEDICAL CLINIC 2021

Registration Form

Prescription Medication Policy

We are happy to help you with your health needs, which includes providing for needed medications prescribed by our physicians.
Please acquaint yourself with the following guideline:

- If you need a refill on your medication, call your pharmacy and tell them which medication you need refilled. They, in turn, will contact us with all the information we need to refill the medicine. If you call us, we will direct you to your pharmacy.

- We DO NOT refill medications after business hours or on weekends. Our physicians on call do not have access to your medical records during those times. Please make sure to contact your pharmacy before you run completely out of medicine to allow ample time for the refill to be processed.

- <u>Please allow 24 to 48 hours</u> to approve or deny any refills. All refills are authorized by the physician, so we must have sufficient time for the physician to review your refill request.

- Our office has "no show, no medication" policy. Failure to show for your appointment will result in a denial for medication.

I have read and understand the above stated medication policy of Acton Medical Clinic.

____________________________ ________________________

Patient Signature Date

ACTON MEDICAL CLINIC

Patient Consent for the Disclosure of Information

I have read the **NOTICE OF PRIVACY PRACTICES** and have had any questions answered by the office. I understand that by signing this form I consent to the following:

A. Sharing information for purposes of treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in my insurance plan.
B. Sharing of information of purpose of payment: You will share all necessary information with my insure(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including but not limited to) claims representatives, data warehouse, billing companies.
C. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

______________________	______________________	__________
Patient's Name (printed)	Patient's Signature (or guardian, if minor)	Date
______________________	______________________	__________
Witness Name (optional)	Witness Signature	Date

Note: If item b is not approved by the patient such that billing to the patient or patient's provider is difficult or impossible, that patient will be requires to pay by cash, check , or credit card prior to being seen by the provider.

I, ______________________, disregard this Disclosure of Information.

ACTON MEDICAL CLINIC

As of January 26, 2021

To Our Patients,

Effective Immediately, there will be a $50.00 charge for No-Show appointment.

There will be a $25.00 charge for canceling an appointment on same day less than a 24-hour notice. We must have a 24-hour notice of all canceled appointments.

Thank You

AMC Administration

Sign Name: ______________________________

Print Name:______________________________

ACTON MEDICAL CLINIC

Authorization for Verbal Release of Protected Health Care Information

I understand that medical information about my condition and treatment may not be released unless I give my permission as provided below.

___ I authorize Acton Medical Clinic staff members to discuss my medical history, diagnosis, treatment plans and prognosis with those listed below. I understand this may include information regarding testing, examination and treatment for HIV, Aids related illness, Mental Health and Drug, Alcohol or Chemical abuse.

_____ DO NOT RELEASE ANY INFORMATION REGARDING MY HEALTH TO ANYONE

___Spouse ______________________________ Phone # ______________________

___Children ______________________________ Phone# ______________________

______________________________ Phone# ______________________

______________________________ Phone# ______________________

______________________________ Phone# ______________________

___Parent ______________________________ Phone# ______________________

______________________________ Phone# ______________________

___Other ______________________________ Phone# ______________________

______________________________ Phone# ______________________

______________________________ ______________________ ____________

Patient Signature or Representative   Relationship to Patient   Date

______________________________ ____________ ____________

Witness   Title   Date

ACTON MEDICAL CLINIC
PO BOX 5334
2006 Fallcreek Hwy
Granbury, Texas 76049
817-326-3440 Fax 817-910-9421

JP Letellier, MD   P. Stephen Bishop, DO   Richard Neckar, NP
Summer Cumba, PA-C   Erin Swelnis, APRN

Authorization for Release of Medical Information

Patient____

DOB ____/____/______   SS# _____/____/______

I hereby authorize: _______________________________________

Address____

Phone : ______________________ Fax :______________________

To Release to Acton Medical Clinic all records including but not limited to medical, surgical, psychiatric, and /or substance abuse (drug or alcohol) information on the abovenamed patient. I hereby authorize you to furnish transcripts or photocopies of the medical records. Informationto be released:

______History and Physical   _____ Office Notes   _____Procedure Notes
______ EKG's/ X-Ray Reports   _____Last Labs   _____Vaccination Records
______ER Records   _____All Hospital Records   _____ Discharge Summary

For Date of Service__________________

The purpose for which this information is being released________Continued care with PCP________

I understand that my records are protected under the Federal Confidentiality Regulations Disclosure Act 42CFR Part 2 along with Texas Senate Bill 667 and can not be disclosed without my written authorization unless otherwise provided for in the regulations. I understand the above information beinreleased could contain reference to or results to HIV antibody (AIDS) testing. I understand that I may revoke this authorization at any time except that action in reliance on it (i.e. probation, parole, etc.) and that in ant event, this authorization expires automatically as described below. I understand that this authorization will expire 180 days from the date of my signature (below). Or sooner at any written request.

Signed:______________________________________ Date:____________________

Witness:___________________________________ Relationship to pt:________________