PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Full Legal Name (First) (Middle) (Last)					Name Normally Used (Nickname)
Address (Number) (Street)					(Apt. No.)
City		State	Zip	Social Security No.	Home Phone
Date of Birth	Age	Sex	Marital Status	Occupation	
Employer Name	Employer Street Address			City	State / Zip
Business Phone (Including Extension)				Patient's Driver's License No.	State
Other Physicians You See					
How Did You Hear About Us?					

SPOUSE'S INFORMATION					
Full Legal Name (First) (Middle) (Last)					Occupation
Address (If Different From Above)		City		State / Zip	Home Phone
Employer Name	Street Address	City	State	Zip	Business Phone (Ext)

INSURANCE INFORMATION				
Primary Insurance Company Name		Group No.		ID/Certificate No.
Subscriber Name		Where to Send Claim		
Secondary Insurance Company Name		Group No.		ID/Certificate No.
Subscriber Name				
Other Insurance Information				

EMERGENCY INFORMATION			
Person to Notify in Case of Emergency			Relationship
Address (Number) (Street)			(Apt. No.)
City	State	Zip	Home Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

INSURANCE BENEFITS AUTHORIZATION AND ASSIGNMENT

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our administration office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to ALON FAMILY HEALTH for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize ALON FAMILY HEALTH to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from ALON FAMILY HEALTH on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement A photocopy of this assignment is to be considered as valid as the original.

I accept the terms of this agreement.

SIGNATURE: _____

PATIENT, GUARDIAN, OR LEGAL REPRESENTATIVE

DATE: _____

Revised: July 2020

CONSENT FOR TREATMENT

1. I consent to any treatment, test or procedure ordered by and given under the supervision of a physician. (Surgical procedures and anesthesia require additional consent.)
2. I acknowledge that no guarantees have been made as to the results of the hospital care and medical treatment hereby authorized.
3. I understand that I am fully responsible for all articles (money, radios, jewelry, dentures, eyeglasses, etc.) and clothing which I retain in my possession (in my room) and for any other articles and/or clothing which may be brought to me while I am a patient at Alon Family Health. I understand that Alon Family Health and its associates are not responsible for loss or damage to any property, which is not turned in for safekeeping.
4. Texas law permits the disclosure of patient health care information without authorization in certain specific settings, including disclosure for payment purposes, for continuing care and to an organ procurement organization.
5. I acknowledge that I have been given a copy of the "Patient Rights and Responsibilities" for my personal use.
6. I acknowledge that I have been given a copy of Alon Family Health's "Notice of Privacy Practices" for my personal use.
7. I acknowledge that I may request the form for Advance Directives from the nursing staff and/or the physician at any time.
8. The physician's office has my consent to leave telephone and/or text messages at my home or as otherwise instructed.
9. I acknowledge the Alon Family Health uses a-prescribing to facilitate medication management for the patient and the patient's medication history will be uploaded through a RX HUB. I also understand that immunization history will be uploaded from the Health Department as well as sent to the Health Department via electronic interface.
10. I acknowledge that I have been given a copy of the "Office Visit Cancellation Policy."
11. I acknowledge that I have been given a copy of the "Patient Financial Responsibility Policy."

NOTE: This statement is to be signed by ALL patients on a yearly basis at the time of registration. When the patient is a minor. parent or legal guardian must sign the statement.

SIGNATURE: _____

PATIENT, GUARDIAN, OR LEGAL REPRESENTATIVE

_____

INSURED CERTFICATE HOLDER

DATE: _____

Revised: July 2020

PERSONAL HEALTH CONTACT

Thank you for choosing Alon Family Health for your health care needs. We appreciate the opportunity to care for you and your family. Please read and sign at the bottom.

1. **Hours of Operation:** We are available 8:00 AM-8:00 PM Monday through Saturday through telemedicine. For after hour emergencies, an on-call practitioner is available through our answering service or seek immediate care at the nearest Emergency Room.
2. **Hospital:** Our team utilizes all major San Antonio and surrounding area hospitals through coordination with staff hospitalists.
3. **Appointment Time:** We strive to stay on time with our appointments. In order to assist us with this, we ask that you arrive or login at least 15 minutes prior to your scheduled appointment. Patients arriving past their appointment time may need to be rescheduled.
4. **Annual Physicals:** We emphasize preventive care as a valuable tool for better health. Appointments for physicals will be devoted to preventive services only, an additional problem will need to be addressed at a follow-up visit.
5. **Cancellations:** We require at least 24 hours in advance when cancelling or rescheduling your appointment. If you fail to cancel or reschedule your appointment, this may be considered a no-show or missed appointment. After 3 missed appointments, we may decide to terminate care. A $25.00 fee will be charged for each NO-SHOW appointment.
6. **Refills:** We have found that processing refills through your pharmacy is the most efficient and accurate method and suggest you contact them first to send us the request. No refills will be done after hours or on weekends except in cases of a medical emergency (defined as a threat to life, limb, or eyesight). Please allow 3 business days to process refill requests and 5 business days if a prior authorization is needed from your insurance.
7. **Payments:** All applicable fees, deductibles, coinsurance or copays must be paid at the time of your service. This office will verify your benefits to the best of our ability once you supply your correct insurance information. Verification of coverage does not mean that all services rendered will be covered during your visit; however, and uncovered services may be your responsibility to pay. Outstanding balances must be paid prior to further appointments.
8. **Staff Support:** Our practitioners and staff are dedicated to your health. Because your physician or practitioner is not always immediately available, many questions or are addressed by communication through our staff. If you desire to speak with your physician, it is appropriate to schedule an appointment. Our nurses and medical assistants are extensions of our physicians and serve as valuable resources in delivering timely care, so please treat them with respect. Any discourteous behavior towards our staff will not be tolerated and result in termination of care.
9. **Paperwork:** We are happy to complete paperwork/forms related to your health care, and we ask that you make an appointment specifically devoted to completing these forms.
10. **Noncompliance:** Your total health is the result of a committed partnership between you and your physician. We reserve the right to discontinue this relationship for noncompliance with health your health plan or any of the above policies.

SIGNATURE: _____

PATIENT, GUARDIAN, OR LEGAL REPRESENTATIVE

DATE: _____

PATIENT RIGHTS & RESPONSIBILITIES

I. PATIENT RIGHTS

a. ALON Family Health is owned and operated by Rolando Perez, Jr, MD.
b. The privacy of all patients shall be respected at all times. Patients shall be treated with respect, consideration, and dignity.
c. Patients shall receive assistance in a prompt, courteous, and responsible manner.
d. Patient disclosures and medical records are considered confidential. Except as otherwise required by law, patient records and/or portions of records will not be released to outside entities or individuals without patients' and/or designated representatives' express written approval. Patients are given the opportunity to approve or refuse the release of their medical records.
e. Patients have the right to know the identity and status of individuals providing services to them.
f. Patients have the right to change providers if they so choose. Patients are informed of the credentials of all staff who will be providing care during the patients' stay.
g. Patients, or a legal authorized representative, have the right to thorough, current, and understandable information regarding their diagnosis, treatment options, prognosis, if known, and follow-up care. All patients will sign an informed consent form after this information has been provided and their questions answered. When it is medically inadvisable to give such information to the patient, the information is provided to a person designated by the patient or to a legally authorized person.
h. Unless participation is medically contraindicated, patients have the right to participate in all decisions involving their health care.
i. Patients have the right to refuse treatment and to be advised of the alternatives and consequences of their decisions. Patients are encouraged to discuss their objectives with their providers.
j. Patients have the right to refuse participation in experimental treatment and procedures. Should any experimental treatment or procedure be considered, it shall be fully explained to the patient prior to commencement.
k. Patients have the right to make suggestions or express complaints about the care they have received and to submit such to Rolando Perez, Jr., MD who will complete an "Incident Notification" and bring the issue to the attention of ALON Family Health in a timely manner so the grievance may be addressed.
l. Patients have the right to be provided with information regarding emergency and after-hours care.
m. Patients have the right to obtain a second opinion regarding the recommended procedure. Responsibility for the expense of the second opinion rests solely with the patient.
n. Patients have the right to a safe and pleasant environment during their care.
o. Patients have the right to an interpreter if required.
p. Patients have the right to be provided informed consent forms as required by the Laws of the State of Texas.
q. Patients have the right to truthful marketing and/or advertising regarding the competence and capabilities of the physicians and staff.
r. Patients have the right to have copies of their Advance Directives and Living Wills in their medical records. In the event of an emergency, the patient will be transferred to the appropriate facility, which will be notified of such Advance Directives and/or Living Wills, as defined by state law.
s. Patients will be provided, upon request, all available information regarding services available at the Practice, as well as information about estimated fees and options for payment.
t. If applicable, patients will be informed of the absence of malpractice insurance coverage.
u. Patients have the right to approve the release of their medical records to other care providers, legal representatives, and other persons authorized by the patient.
v. Patients have the right to exercise their rights without being subject to discrimination or reprisal.
w. Patients have the right to be free from harassment or abuse.

II. PATIENT RESPONSIBILITIES

a. Patients are expected to provide complete and accurate medical histories, to the best of their ability, including providing information on all current medications, over-the counter products, dietary supplements, and any allergies or sensitivities.
b. Patients are responsible for keeping all scheduled appointments and complying with treatment plans to help ensure appropriate care.
c. Patients are responsible for reviewing and understanding the information provided by their physician or nurse. Patients are responsible for understanding their insurance coverage and the procedures required to ensure payment.
d. Patients are responsible for providing insurance information at the time of their visit and for notifying the receptionist of any changes in information regarding their insurance or medical information.
e. Patients are responsible for paying all charges for copayments, coinsurance and deductibles or for non-covered services at the time of the visit unless other arrangements have been made in advance with ALON Family Health.
f. Patients are responsible for treating physicians, staff and other patients in a courteous and respectful manner .
g. Patients are responsible for asking questions about their medical care and to seek clarification from their physician of the services to be provided until they fully understand the care they are to receive.
h. Patients are responsible for following the advice of their provider and to consider the alternatives and/or likely consequences if they refuse to comply.
i. Patients are responsible for expressing their opinions, concerns, or complaints in a constructive manner to the appropriate personnel at the Practice.
j. Patients are responsible for notifying their health care providers of patient's Advance Directives, Living Wills, Medical Power of Attorney or any other directives that could affect their care. In the event of an emergency, the patient will be transferred to the appropriate facility. The facility will be notified of the existence of the Advance Directive, if applicable, and will be provided with a copy.
k. The patient should expect to be provided a copy of the Patient Rights and Responsibilities prior to the date of a procedure.

QUESTIONS OR CONCERNS

You and your family should feel you can always voice your concerns. If you share a concern or complaint, your care will not be affected in any way. The first step is to discuss your concerns with your physician, nurse, or other caregiver. If you have concerns that are not resolved, please contact ALON Family Health at (210) 534-2566, or manager@alonfamilyhealth.com.

Should you continue to remain concerned, you may contact the Texas Medical Board Investigations Department MC-263, 1-800-201-9353, P.O. Box 2018, Austin, TX 78768-2018, or your Ombudsman at www.cms.hhs.gov/center/ombudsman.asp.

SIGNATURE: _____

PATIENT, GUARDIAN, OR LEGAL REPRESENTATIVE

DATE: _____

Authorization: Use & Disclosure of Protected Health Information

PATIENT INFORMATION:	INFORMATION SOURCE (Release from):
Name:	Name:
Street:	Street:
City:	City:
State/Zip:	State/Zip:
Telephone:	Telephone:
SSN: DOB:	Fax:

SEND INFORMATION TO:
ALON Family Health 11503 N.W. Military Hwy, Suite 111, San Antonio, TX 78231 Phone: (210) 534-2566 FAX: (210) 510-2914

Information To Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

Please check type of information to be released:

☐ Complete health record	☐ Operative report and pathology	☐ Discharge summary
☐ History and physical exam	☐ Consultation reports	☐ Progress notes
☐ Laboratory test results	☐ X-ray reports	☐ X-ray films / images
☐ Photographs, videotapes	☐ Complete billing record	☐ Itemized bill
☐ Abstract of health record (*all typed physician reports and test results)*		

☐ Other, (specify) _____

Purpose of Request

☐ Treatment or consultation	☐ At the request of the patient	☐ Billing or claims payment

☐ Other (specify) _____ _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I authorize the information source to release my medical or billing records containing information in reference to **Drug and/or Alcohol Abuse** and treatment: ***Initial One:*** **Yes**_____ **No**_____ **Not Applicable** _____

I authorize the information source to release my medical or billing records containing information in reference to **Mental Health or Psychiatric** treatment: ***Initial One:*** **Yes**_____ **No**_____ **Not Applicable** _____

I authorize the information source to release my medical or billing records containing information in reference to **HIV/AIDS (Acquired Immunodeficiency Syndrome)** testing and/or treatment: ***Initial One:*** **Yes** _____**No** ____ **N/A**_____

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Record Custodian at the requesting CHRISTUS Santa Rosa Family Health Center. Unless revoked, this authorization will expire on the following date or event _____or 180 days from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed.

I authorize the information source to release the protected health information specified above.

Signature: _____ Date: _____

Authority to Sign if not patient: _____

Identity of Requestor Verified via: ☐ **Photo ID** ☐ **Matching Signature** ☐ **Other, specify** _____

Verified by: _____