CHI St. Luke's Health

REGISTRATION FORM - (PLEASE PRINT)

Date:	**PCP's** last name:	First:	Middle:	PCP Ph:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Religion Preference:

Email:	Language:	Interpreter Needed: ❑ Yes ❑ No

Street address: Apt #	Social Security:	Home ph: ( ) Cell ph: ( ) Work ph: ( ) To which # do you wish to receive appointment reminders?

P.O. Box:	City:	State:	ZIP Code:

Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:	Employer:	Employer ph: ( )

Pharmacy's Name	Pharmacy's Ph: ( )

How did you hear about us:

INSURANCE INFORMATION

(Please give your insurance card & ID to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )

Occupation:	Employer:	Employer address:	Employer ph: ( )

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Co-payment: $ _____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

Patient's relationship to subscriber:
❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

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 my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

_____ _____

Patient/Guardian signature *Date*

AGAPE PHYSICIANS

6769 Lake Woodlands Dr., Ste. E, The Woodlands, Texas 77382 ♦ Phone (281) 210-1200 ♦ Fax (281) 210-1210

Vaccine Policy

Our practice believes in the effectiveness of immunizations to prevent serious illness and save lives far beyond the risk of adverse effects from immunizations. Vaccines are safe for our patients, and we recommend that our patients receive the recommended vaccines published by the American Academy of Pediatrics and Centers for Disease Control. It is clear based on all available literature and current studies that vaccines do not cause autism or other developmental disabilities.

We believe that vaccinating children and young adults is a very important health-promoting intervention that we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule, given are the results of decades of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

We also acknowledge and respect that parents have concerns about the number and safety of vaccines. We will do our best to answer all of your questions based on scientific knowledge and put your fears at ease. If you still choose to not vaccinate your child, we suggest you find a practice that will better fit your needs.

Sincerely,

Peter C. Bigler, MD

Jessica P. Belsha, MD

Erika B. Goodson, MD

Christi Dodd, PA-C

Brittany Besong, PA-C

Demetria Borges, PA-C

Guardian Signature:_____ Today's Date:_____/_____/_____

Child's Name:_____ DOB:_____/_____/_____

Baylor College of Medicine

CHI St. Luke's Health

Imagine better health.℠

PARENTAL PREAUTHORIZATION FOR MEDICALCARE TO CHILDREN

For families who are ongoing patients of the Practice, it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present during treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize the Practice and its personnel to deliver medical care to my (our) child listed below:

Name of Minor: _____ Date of birth: _____

Please try to contact me (us) regarding the healthcare of my (our) child at the following number(s):

1. Parent's name: _____

   Phone (office/home): _____

2. Parent's name: _____

   Phone (office/home): _____

3. Other (relationship): _____

   Ph.one (office/home): _____

Signature: _____

Date: _____

Print name and relationship: _____

NOTE: If any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no parent, etc.) is in place, please explain in the space below with your signature, printed name, and a phone number at which you can be contacted.

Signature: _____ Date: _____

Printed name: _____ Phone: _____

Pediatric History

Patient Name: _____
DOB: _____
Age: _____

Patients Previous Doctor: _____
Present Health Concerns: _____
Allergies to Medications: _____

Pregnancy

Maternal illness during pregnancy? ☐☐ Yes ☐☐ No
If so, what type? _____
Type of delivery? (circle one) C-Section / Vaginal
If C-Section why? _____
Medications: _____
Length of pregnancy: _____weeks

Family History

Parents of the child in good health? ☐☐ Yes ☐☐ No
Siblings of the child in good health? ☐☐ Yes ☐☐ No

Please list medical conditions for the following family members:

Relative	Medical Conditions
Mother	
Father	
Siblings	
Siblings	
Siblings	
Maternal Grandparents	
Paternal Grandparents	

Social History

Are the parents of the child:
☐☐ Married ☐☐ Divorced ☐☐ Separated ☐☐ Deceased
This child lives with:

Name	Age	Relationship	Highest Education

Is the child in daycare, pre-school, nanny or relatives?
_____

Social Questions	Yes	No
Are there pets in the home?		
Are there smokers in the home or people who smoke?		
Do you have a pool, spa, or pond?		
Does your child always use a car seat or seat belt?		
Does your child wear a helmet when riding a bike, etc.?		
Do you have a record of immunization?		
Is there violence in the home?		
Are there guns in the home?		
Any concerns with lead exposure		
Screen time per day? (TV, Computer, Phone, tablet, etc.)	___hrs / day	

Milk intake now: ☐☐ Cow milk (☐☐ non-fat ☐☐ 1% ☐☐ 2% ☐☐ whole) ☐☐ Other
Average ounces per day_____oz

Birth History

Place of birth: _____
Adopted? ☐☐ Yes ☐☐ No Birth Weight:_____Length:_____
Problems at birth? ☐☐ Yes ☐☐ No Jaundice? ☐☐ Yes ☐☐ No
Breathing Problems? ☐☐ Yes ☐☐ No Antibiotics? ☐☐ Yes ☐☐ No
Other problems (explain)? _____
_____
Stay in NICU? ☐☐ Yes ☐☐ No If so, why? _____
Was child breastfed? ☐☐ Yes ☐☐ No If so, how long? _____

Past Medical History

Allergies? ☐☐ Yes ☐☐ No List Allergies _____

Has your child had:	Yes	No
Frequent ear infections		
Eye problems		
Frequent colds, sore throats		
Asthma, pneumonia, recurring cough		
Heart murmur or heart problems		
Problems with urine infections		
Frequent diarrhea or constipation		
Convulsions / seizures		
Eczema or skin conditions		
Anemia or blood problems		
Feeding problems		
Has your child seen any specialists?		
Does your child homeopathic or herbal medicines?		

List other medical problems: _____
_____
Age child: Rolled Over?_____Sat Alone?_____Walked?_____

If not applicable, leave blank	Yes	No
Was the child saying words by 18 months?		
Does the child have trouble sleeping?		
Has the child had trouble in school?		
Does the child get along with other children?		
Does your child suck his / her thumb?		
Does your child wet the bed?		
Any problems with toilet training?		
Hyperactivity?		
Nightmares or sleep issues?		
Speech problems?		
Problems with discipline?		

Medications child takes regularly:_____
_____
Hospitalizations & Operations
_____ Date
_____ Date
_____ Date

Patient's Pharmacy: _____

Authorization to Release Protected Health Information to Delegate

Patient Name (print):_____ **DOB:** _____

By signing this form, I authorize CHI St. Luke's Medical Group to disclose protected health information such as office consultations, labs, radiology and other test results to the person or people listed below. I understand that it is my responsibility to update this release form if necessary and/or remove delegates.

CHI St. Luke's Medical Group May Release my protected health information to the following people:

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Preferred Contact Method

CHI St. Luke's Medical Group will often contact patients for appointment reminders and testing results. Please indicate the method in which our office may contact you and or leave messages on authorized phone numbers.

_____Initial Primary Contact Number _____ cell/home/work/other

_____Initial Secondary Contact Number _____ cell/home/work/other

_____Initial I do not wish to be contacted in any other manner than a direct conversation, no messages may be left.

Patient /Guardian Signature_____

Authorization and Assignment Acknowledgement Form

My signature certifies I have read and understand the content of the Auth. & Assignment Acknowledgement document.

Patient / Guardian Signature_____

HIPAA **Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **Date:** _____

Patient / Guardian Signature

_____ _____

Relationship (if not the patient) **SLMG Witness**

Patient Name: _____ **Patient DOB:** _____/_____/_____ **Date:** _____/_____/_____

Peter Bigler, MD Erika Brito-Goodson, MD Jerissa Belsha, MD Brittany Besong, PA-C Christi Dodd, PA-C Demetria Borges, PA-C

Wellness Update

Do you consistently experience any of these symptoms?	**Yes** (how often/how long do symptoms last?)	**No**
Runny Nose		
Itchy Nose		
Stuffy Nose		
Itchy Eyes		
Watery Eyes		
Frequent Sneezing		
Itchy Mouth/Lips/Throat		
Post Nasal Drip (drainage down the back of the throat, clearing throat)		

Do you currently take over-the-counter (OTC) for the management of your allergy symptoms? □**Yes** □**No**

If yes, name of medication and last date taken: _____

Please indicate below symptoms/conditions you've experienced during the last 1-2 years

□ Sinus related issues (sinus pressure/pain, headaches, sinusitis)

□ Eczema

□ Chronic colds (lasting longer than 2 months)

□ Migraine Headaches

□ Feeling of fatigue, irritability, and restlessness

□ Consistent or Re-Occurring cough

□ Asthma

Patient/Guardian Signature: _____ **Date:** ____/____/____

Patient Phone: _____

FOR PROVIDER USE ONLY:

Order Allergy Test: □ **Yes** □ **No**

Date of last ENT exam: _____/_____/_____

Provider Signature: _____ **Date:** _____/_____/_____

CHI St. Luke's Health

Authorization and Assignments

Thank you for choosing CHI St. Luke's Health Medical Group. We realize you have a choice in selecting healthcare and we are honored you have chosen us. Our staff is committed to providing our patients with the highest quality of care possible. In doing so, we would like to provide you with information regarding our office policies. Please feel free to contact or office anytime Monday – Friday during routine business hours if you have questions, concerns, or suggestions.

Office Policy

Our providers participate with many health plans and as a courtesy to our patients, we file claims with these companies. It is ultimately your responsibility for the full and timely payment of your account.

Check In

Please be prepared to submit the following documents when checking in for each visit. These documents will be scanned and saved as part of your patient record.

- Current Insurance Card
- Current Photo Identification
- Update to contact information such as home address, phone numbers, contact information, email address, employer information, etc.

Verification of Benefits

We will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain a verification of coverage, you may be asked to pay in full or reschedule your visit for a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan to pay for services received.

Payment of Patient Responsibility

Payment of your estimated patient responsibility is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance amounts applicable for each visit and or procedure. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding eligibility and benefits. For your convenience we accept cash, checks, most major credit cards and debit cards.

NSF Checks/Denied Credit Card Payments

You will be charged a $25.00 fee should a payment be returned for insufficient funds. This fee applies to payments made at our front desk, mailed in to the Business Office, electronically via the internet, or payments by phone.

Past Due Amounts

In the event your account becomes past due, and all efforts to collect payment have failed, your account may be referred to a collection agency.

Additional Services Identified During Treatment

Please be aware additional charges may be incurred if during the course of a physical exam a physician addresses, diagnoses, or treats problem-focused health concerns unknown at time of check in.

Non Covered Services

Please be aware certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", "cosmetic", or simply "non-covered" by your health plan. You are responsible for payment of these services. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. This clinic will provide medically necessary care based on patient's needs, not a patient's insurance coverage. This clinic is not responsible for knowing your plant's specific benefit and coverage limitations.

Third Parties Insurance

We do not file insurance claims to non-contracted third parties involving automobile accidents, accidental injury, property insurance, etc. You will need to pay in full at the Time of Service and file the claim with your insurance company. An itemized statement may be obtained by calling our business office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Appointment Scheduling

Please be advised, as a courtesy, an automated service will call the primary phone number listed on file to remind you of your appointment date and time. You must notify the office within 24 hours of your scheduled appointment if you are unable to keep your appointment. Failure to notify the office within 24 hours may result in a $25.00 assessment to your account. Repeated failure to call and cancel your scheduled appointment without the proper 24 hour notice may result in your dismissal as a patient.

Forms/Medical Letters

We are happy to assist you by completing forms and generating medial letters for you upon your request. The fee for this service varies depending on the form or letter, but most do not exceed $25.00 per form. Payment is collected when you pick up the documents. Please allow 10 business days.

Medical Records

Requests for your medical records must be in writing via a special release form. Release of records is managed via an outside vendor. The cost is $25.00 for the 1st 20 pages and $.50 for each additional page. You will pay the outside vendor for these copies.

Office Hours

While appointment times vary for each provider, our office staff is available by telephone 8:00am to 5:00pm Monday through Friday. Because our providers and nurses are often tending to patients, it is typically necessary for you to leave a message. So we may assist you in a timely manner, please leave pertinent information to include the reason for your call and best number to call. We have an answering service to take your calls before and after our scheduled office hours.

- Emergency Needs – always call 911
- Prescription Refills – call during regular office hours and if leaving a message, provide your name, the medication, your pharmacy name, location, and phone number. Refills of controlled substances and/or narcotics MUST be filled by speaking with a medical staff member.

Authorization to Release Information

I hereby authorize CHI St. Luke's Health Medical Group to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of an examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked in writing.

Assignment of Benefits

I hereby assign all medical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct insurance carrier(s), include Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) directly to CHI St. Luke's Health Medical Group 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.

Financial Responsibility

I acknowledge I have requested medical services from CHI St. Luke's Health Medical Group, 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 agree to pay CHI St. Luke's Health Medical Group for all services and products administered. I understand and acknowledge that any monies collected prior to the date services are rendered or products are administered will be applied as a deposit towards total charges assessed for the services rendered. The deposit shall not be considered payment in full. If I participate in a managed care plan, such as an HMO or PPO, I promise to pay for any services or products administered that are not covered under the plan as a result of inaccurate, incomplete or untimely patient information provided by me to the clinic and for any out-of-network charges.

I further understand that fees are due and payable on the date the 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.

My signature certifies I have read and understand the above content of this document.

_____	_____
Print Patient Name	Patient Date of Birth
_____	_____
Patient/Guardian Signature	Date