BLANCO REGIONAL CLINIC PATIENT REGISTRATION

Date_____

Patient Name _____Date of Birth_____

Address_____City, State, Zip _____

E-mail_____ Gender M F Age_____ Minor _____

Home Phone ( )_____Cell( )_____Work( )_____Ext____

Driver's License # _____ Social Security#_____

Marital Status:

Married Widowed Single Divorced Separated

Select one of the following Race/Ethnic Groups:

Hispanic Black White American Indian Asian Other Race

Patient Employer/School_____

Employer/School Address_____

Employer/School Phone _____

Spouse's Information

Spouse's Name _____Date of Birth _____

Employer_____Social Security # _____

Minor Information

Guardian/Custodial Parent Name_____

Guardian/Custodial Parent Address_____

Home Phone _____Cell Phone_____Work_____

Employer_____Social Security # _____

In Case of Emergency, Contact

Name_____Contact Phone # _____

Name _____Contcat Phone # _____

BLANCO
Regional Clinic

BLANCO REGIONAL CLINIC 825 FOURTH STREET 830-833-5581

Thank you for choosing Blanco Regional Clinic as your health care provider. We are committed to providing the highest quality medical care and personal service to our patients. We ask that you read and sign our Financial Policy prior to your initial visit if you have any questions regarding our payment policies, please do not hesitate to contact our billing department.

Statements: Statements are sent out once a month. Payment is expected upon receipt of statement. Accounts unpaid after the third statement is sent out will be subject to being turned over to an outside collection agency. Accounts will also be subject to any collection fees incurred by Blanco Regional Clinic. Please advise the front office staff of any changes in your address, as statements returned due to invalid address my also be turned over to our collection agency.

Returned Checks: Checks returned will be subject to a $35 fee. We will contact you immediately to resolve the matter, but if no explanation or payment is received within 10 business days, the matter will be turned over to the District Attorney's Office.

Payment: All co-pays, deductibles and co-insurance will be collected in **full at each visit.** All payments that are not paid on your date of service are subject to a $10 processing fee, unless payment arrangements are discussed **prior** to seeing the physician. For your convenience, we accept Cash, Checks, MasterCard, Visa Discover and Amex. Payment is due in full at time of service.

No-Shows: Patient appointments that are not cancelled/rescheduled before the appointment time will be subject to a $25 No-Show fee. All routine physicals and procedural appointments will result in a $35 fee.

Patients with Insurance Coverage

We recommend you spend time familiarizing yourself with your insurance benefits. We will do everything possible to see that your receive the full benefits of your policy. As a courtesy and convenience to you, we file claims directly to your insurance company. While it is our intention to assist you, your insurance policy is a contract between you and your insurance company and it is your responsibility that all charges are paid in full. We cannot become involved in disputes between you and your insurer regarding: deductibles, co-payments, covered charges, medical necessity, diagnosis codes or "usual and customary fees". Please be aware that some services, exams, or lab work performed, may be non-covered or considered unnecessary under your insurance plan. If you are not certain, please contact our office for assistance and call your insurance company directly.

If we are unable to verify your benefits before your visit, you will be considered private pay and required to pay all services up front. To prevent billing errors, we ask that you present your current insurance card at each visit and provide us with updated information as changes occur.

I have read and fully understand the terms of this Financial Policy.

Signature:_____ **Date:**_____

HIPPA- Privacy Notice

I am aware that I may review Blanco regional Clinic's HIPPA privacy notice at any time and understand that I may request a copy. Initials_____

Blanco Regional Clinic Care Agreement

I authorize the physicians at Blanco Regional Clinic to administer medical treatment as deemed necessary. Initials_____

Nurse Practitioner/Physician Assistant Agreement

I authorize the physicians of Blanco Regional Clinic to instruct their Physician Assistant/Nurse Practitioner and RN/LVN/MA providers to assist in certain aspects of my medical care.

I understand that a Physician Assistant/Nurse Practitioner is not a licensed physician and may not treat or diagnose any illness or medical condition except under the supervision/direction of a licensed physician. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Nurse Practitioner....I acknowledge that it is my responsibility to inform staff of BRC that I wish not to see the PA/NP and be scheduled with my assigned physician accordingly. I understand that I may revoke this authorization at any time.

Signature_____ Date_____

Release of Information

I understand that my personal information will not be released to anyone other than myself and that that includes my spouse and or adult children. By **signing** below I give my permission for Blanco Regional Clinic, P.A. to Release my personal information to the following individuals other than myself:

1._____

2._____

3._____

4._____

5._____

Patient Signature:_____Date:_____

Blanco Regional Clinic, P.A.

In order to help you clearly understand our policies and services, please read the following statements, and sign the bottom indicating you accept these rules:

I understand the clinic normally uses Quest Diagnostics Laboratory. If I or my insurance company prefers another lab, **it is my responsibility to inform a medical staff member** before the specimen is being taken so I am not billed for having lab work processed by Quest Diagnostics, instead of another lab. _____intial

All controlled substance prescriptions require at least 3 day notice. I understand there can be a fee for controlled substance prescriptions written without an appointment or if I do not follow the proper protocol for refill. _____intial

I understand there may be a fee for missed appointments or appointments not cancelled within 24 hours. Please notify us as soon as possible if you are unable to keep appointment. _____intial

I understand a fee may be assessed for any paperwork or forms to be completed without an appointment and that it may take up to 10 day to be completed. _____intial

I understand prescription renewals are to be processed through the requested pharmacy and given at least a 72 hour notice. If the prescription is a mail order and requires a written prescription, it may take 3-4 business days to be processed. Refills called in on a Friday may not process until **2-3 business days.** _____initial

I understand that labs, x-ray reports, and other test results need to be reviewed and may take between 3-4 business days to be review by the physician or NP. A staff member will contact you sooner if the results are urgent; otherwise you will be contacted by phone or mail. _____initial

Fees for services:

$10 Controlled substance prescription
$25 medical records for purposes of life insurance or attorney request
$35 for attending physician statements

_____

Patient name signature

Date_____ Date of Birth_____

CONSENT TO GIVE TEST RESULTS

Patient_____Date od Birth_____

I give permission to allow Blanco Regional Clinic to leave results of

_____Blood Test

_____X-rays

_____Cultures, including throat, urine and genital

_____All of the above

On or With

_____Myself only

_____My spouse or significant other (name:_____)

_____other(Name_____)

_____answering machine or my cell phone

_____other specify_____

Signature_____Date_____

HEALTH HISTORY

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.

Patient: _____ Date of Birth: ____ / ____ / _____

Home Address: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep Do you have a living will? ☐ Y ☐ N

MEDICAL CONDITIONS

If either you or a family member has or had any of these conditions, check (√) the box by the condition listed. For family member, indicate their relationship to you (e.g., mother, father, sibling). Please provide a brief description.

Condition	Self	Description	Family Member	Description
Arthritis				
Asthma				
Back Problems				
Blood in Stool				
Bowel Changes				
Cancer				
Chicken Pox				
Dental Problems				
Depression				
Diabetes				
Emphysema				
Hearing Problems				
Heart Problems				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Problems				
Leg Swelling				
Liver Problems				
Lung Problems				
Measles				
Migraine Headaches				
Mononucleosis				
Mumps				
Panic Attacks				
Seizures				
Sexually Transmitted Disease				
Skin Problems				
Stroke				
Thyroid Problems				
Other:				
Other:				
Other:				

PROBLEM CHECKLIST

If you have recently or recurrently noted any of the following problems, please check (√) the box by the condition listed.

General	Fever Sweats Unintended weight change (how much for what period? _____)	Chills Malaise or "feeling ill" Fatigue
Head	Headache	Head Injury
Ears	Ringing Ear pain Ear discharge	Change in hearing Blockage Dizziness
Nose	Congestion Persistently discolored discharge Sinus pressure	Clear discharge Post nasal drip Sinus pain
Throat	Sore throat Laryngitis Itchy throat	Dental problem Persistent hoarseness Snoring
Eyes	Change in vision Flashing or scintillating lights Partial loss of vision Eye pain	Sudden loss of vision Dark spots or "floaters" Eye discharge Itchy or irritable
Heart	Chest pain or pressure Swelling of feet or ankles	Palpitations Racing Heart
Lungs	Trouble breathing Cough	Wheezing Painful breathing
Digestive	Heartburn or acid reflux Nausea Diarrhea Blood in stool Excessive bloating or gas	Abdominal pain Vomiting Constipation Black tarry stool
Bones and joints	Back pain Joint pain	Neck pain Muscle aches
Neurological	Weakness Abnormal sensations Seizures	Numbness Fainting Restless legs
Psychological	Anxious Feeling hopeless or helpless Unable to enjoy life Uncontrollable anger or irritability Wanting to hide, disappear or die	Panic attack Persistent sadness Insomnia Poor appetite or stress eating Wanting to hurt someone
Skin	Abnormal or changing mole Lesions of concern Swollen glands Change in texture	Rashes Dryness Bruising Hair or nail changes

ALLERGIES

Are you allergic or intolerant to any medications? ☐ Y ☐ N If "yes", please list and describe your reaction(s).

_____

_____

_____

SURGERIES

Please list any surgeries or procedures (include colonoscopies) you have had with approximate dates.

_____

_____

_____

MEDICATIONS

Please list any medications you are using including vitamins, herbal supplements and contraception.

PREVENTIVE HEALTH

Please provide the following information:

Caffeine? ☐ Y ☐ N Type:_____ Caffeinated beverages per day?	Alcohol? ☐ Y ☐ N Type:_____ Drinks per week? Quit Date? /
Tobacco? ☐ Y ☐ N Type: _____ Packs per day? Quit date? /	Other substances? ☐ Y ☐ N Frequency?_____ Drug(s)?
Exercise? ☐ Y ☐ N How long? Hrs/ Mins	Number of Days per week?

FOR WOMEN

Please provide the following information:

Number of pregnancies? How many resulted in live birth(s)? Miscarriage(s)? Abortion (s)?	
Date of last period? /	Could you be pregnant now? ☐ Y ☐ N
Last Pap Smear or female exam? /	Last mammogram? /
Method of birth control?	Age at first period? Age at menopause?
Prior abnormal Pap Smear? ☐ Y ☐ N If so, year:	Sexually active? ☐ Y ☐ N
History of human papilloma virus? ☐ Y ☐ N	Planning pregnancy in next year? ☐ Y ☐ N

Is there anything of a sensitive nature you would like to discuss with your physician? ☐ Y ☐ N

ADDITIONAL INFORMATION

Please use this space to complete any of the above questions or provide other relevant information.

Patient Signature or Patient's Legal Representative

Date

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.