PATIENT REGISTRATION FORM (Please print) _____

Patient's Legal Name: (Last) _____(First) _____(MI) ___
Preferred Full Name (if different from above): _____
Patient Social Security Number:_____Date of Birth: _____
Address: _____
City, State, Zip: _____
Phone: Home: _____ Cell: _____ Work: _____
I give permission to release appointment information to whoever answers the phone at my listed phone number(s) Yes No
Gender Identity: Female Male Choose not to disclose
Language: _____ Interpreter Services Required? Yes _____ No_____

E-Mail Address:_____
Pharmacy Name: _____ Phone#: _____
Mail Order Pharmacy: _____
Phone#: _____ **Fax#**: _____

GUARANTOR / POLICY HOLDER INFORMATION (*If not self*) _____
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: Female Male Phone number: _____
Relationship: _____

Insurance Policy (Primary)
Insurance carrier name: _____
Subscriber / Member ID #: _____ Group #: _____

Insurance Policy (Secondary)
Insurance carrier name: _____
Subscriber / Member ID #: _____ Group #: _____

EMERGENCY CONTACT
Name: _____Phone#: _____Relationship: _____

HIPPA AUTHORIZATION
I give permission to my physician to discuss and/or release any medical information concerning my healthcare to the following family members / friends. I am aware that I may revoke or modify this permission at any time in writing.
Name: _____Phone#: _____Relationship: _____
Name: _____Phone#: _____Relationship: _____

GENERAL CONSENT FOR CARE AND TREATMENT_____
TO THE PATIENT: I hereby voluntarily consent to treatment at the facility. I permit the facility and its employees, physicians, and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent for treatment and/or test. I consent to examinations, blood tests (including blood test(s) for communicable diseases such as hepatitis and HIV/AIDS when healthcare providers have been exposed to my blood/fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatment rendered by the facility personnel under the instructions, order or direction of such physician(s).

Patient Signature: _____Date: _____

Please complete the highlighted areas only on this page

Section A: This section must be completed for all Authorizations			
Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4-digit SSN (optional)**
Physician or Facility Name:	**Recipient's Name:** **Primary Care Centers of Texas**		
Fax: _____ **Phone: _____** **Address:**	**1259 FM 1463, Ste. 400** **Katy, Texas 77494**		
	Recipient's Fax # **888-720-2860**	**Recipient's Phone#:** **832-695-9400**	

Request Delivery (If left blank, a paper copy will be provided):

☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly): N/A xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 12/31/2024 **Event:**

Purpose of disclosure: Continuation of Care

Description of information to be used or disclosed

Is this a request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:

☐ Entire Medical record
☐ Lab / Imaging / Procedure reports
☐ Dictation reports
☐ Other
☐ ER information
☐ Admission form
☐ Medication list / sheets
Date(s): _____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☒ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☒ No

If yes, describe: _____

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☒ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient / Patient's Representative:	**Date:**
Print Name of Patient / Patient's Representative:	**Relationship to Patient:**

Communications about My Healthcare

I agree the Provider, or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receive unsecured instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Release of Information.

I hereby permit the practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases including, but not limited to, blood-borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Financial Agreement: I acknowledge that as a courtesy, Primary Care Centers of Texas may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks.

Third Party Collection: I acknowledge Primary Care Centers of Texas may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

Assignment of Benefits: I hereby assign to Primary Care Centers of Texas any insurance or other third-party benefits available for health care services provided to me. I understand Primary Care Centers of Texas has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Primary Care Centers of Texas, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

Medicare Patient Certification and Assignment of Benefit: I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Primary Care Centers of Texas by the Medicare or Medicaid program.

Consent to Telephone Calls for Financial Communications: I agree that, in order for Primary Care Centers of Texas, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Primary Care Centers of Texas or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Primary Care Centers of Texas or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Refills: If you need a refill on your medication, we ask that you call **your pharmacy** and tell them which medication you need to be refilled. They, in turn, will fax or call us with all the information we need to refill the medication. **If you call us, we will ask you to call your pharmacy. We do not refill medications after business hours or on weekends.** Our providers do not have access to your medical records after business hours. Please make sure you contact your pharmacy **at least 3 business days before you run out of the medication** to allow time for the refill to be processed – refills requests are allowed up to 72 hours for processing once received. A recent office visit may be necessary before any refills are given. We cannot prescribe medications for conditions that have not been addressed in the clinic. We typically have same-day availability for appointments.

AFTER BUSINESS HOURS, WEEKENDS AND HOLIDAYS

Our normal business hours are 8 AM to 12 PM and 1 PM to 5 PM, Monday through Friday. We are closed on major US holidays. In case of an emergency, a life-threatening situation, or concerning symptoms, call 911 or go to the nearest emergency room. Our providers do not have access to your medical records after business hours, weekends, or major holidays. If you would like to schedule a routine appointment, please call during business hours.

Patient Signature: _____ Date: _____

Current Medications

❒ **No Current Medications**

***** Medication/Equipment List- Only Include Current Medications/Vitamins/Medical Equipment/etc.**

Name of Medication	Strength	Dosage	30- or 90-Day Supply	Last Prescribed By	Need Refill

Medical History

Reason For Visit: ❒ **Checkup** ❒ **New Health Problem** ❒ **Establish Care / Medication refills** ❒ Other _____

(Please check all that apply)

❒ Allergies	❒ Enlarged Prostate	❒ Incontinence
❒ Anemia	❒ Frequent Falls/Balance Issue	❒ Kidney (Renal) Disease
❒ Anxiety	❒ Gall Stone	❒ Kidney Stones
❒ Arthritis	❒ GERD/Acid Reflux	❒ Shortness of Breath
❒ Asthma	❒ Heart Disease	❒ Skin Condition
❒ Blood Clots	❒ Hearing Loss	❒ STD Type:
❒ Cancer Type:	❒ Hepatitis Type:	❒ Stroke
❒ Diabetes Type:	❒ High Blood Pressure	❒ Thyroid Disease
❒ Depression	❒ High Cholesterol	❒ Vision Loss
❒ Emphysema/COPD	❒ Irritable Bowel Syndrome	❒ Other:

List any additional items related to above:

_____

❒ Pregnant ❒ Breast Feeding Date of last Menstrual Cycle _____ # of Births: _____

Allergies ❒ No Known Allergies

Medication/Food: _____ Reaction: _____❒ Critical

Medication/Food: _____ Reaction: _____❒ Critical

Other Allergy: _____ Reaction: _____❒ Critical

Past Surgeries/Hospitalizations ❒ No Surgeries ❒ No Hospital Stays

Year: _____Procedure/Reason: _____Facility: _____

Year: _____Procedure/Reason: _____Facility: _____

Year: _____Procedure/Reason: _____Facility: _____

Patient Name: _____ Date of Birth_____

Medical History- *Continued*

Smoker: ❒ Never Former-Years Smoked: _____ ❒ Current (Age Started _____) Packs per day_____

Other Tobacco: ❒ Never ❒ Former-Years Used _____ ❒ Current (Age Started _____) Cans per day _____

Alcohol Use: ❒ Never ❒ Former ❒ Occasional ❒ Moderate ❒ Frequently Type: Beer Wine Liquor

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Partner ❒ Widow

Occupation: ❒ Student ❒ Full-Time ❒ Part-time ❒ Homemaker ❒ Retired ❒ Disabled ❒ Not Employed

Stress Level: ❒ Low ❒ Moderate ❒ High What are your stressors? _____

Health Screenings

Lab work	Date	Facility	Abnormal? Y N
Pap smear	Date	Facility	Abnormal? Y N
Mammogram	Date	Facility	Abnormal? Y N
Colonoscopy	Date	Facility	Abnormal? Y N
Bone Density	Date	Facility	Abnormal? Y N
Lung Cancer Screen	Date	Facility	Abnormal? Y N

Vaccinations

Influenza	Date	Tetanus	Date
Covid-19	Date	Other:	Date
Pneumococcal	Date	Other:	Date
Shingles	Date	Other:	Date

PREVIOUS PRIMARY CARE PROVIDER

NAME: _____

PH#: _____ FAX#:_____

SPECIALISTS PROVIDER NAME:

Dr: _____ Phone: _____ Reason: _____

Dr: _____ Phone: _____ Reason:_____

Family Medical History ❒ No Significant Family History Known

Member	Status / Age	Health Conditions	Cause of Death / Age at time of Death
Daughter	❒ Alive ❒ Deceased ❒Unknown AGE:		
Father	❒ Alive ❒ Deceased ❒Unknown AGE:		
Son	❒ Alive ❒ Deceased ❒Unknown AGE:		
Spouse	❒ Alive ❒ Deceased ❒Unknown AGE:		
Mother	❒ Alive ❒ Deceased ❒Unknown AGE:		
Grandparent	❒ Alive ❒ Deceased ❒Unknown AGE:		

Patient Name: _____ Date of Birth_____