CHAMPIONS POINT FAMILY CLINIC *Health For Life*

PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

First Name	Last Name	Middle Initial	Date of Birth	Age

Sex: (check one) ☐ Male ☐ Female	Social Security #	Mobile Number	Alternate Number	Email

Address	Apt #	City	State	Zip

Race: (check one)

☐ American Indian/Alaskan ☐ Black or African American ☐ Native Hawaiian or other Pacific Highlander ☐ White ☐ Hispanic ☐ Other: _____

Ethnicity: (check one) ☐ Hispanic ☐ Non-Hispanic	Preferred Language	Preferred Pharmacy & Location	Phone Number

Emergency Contact	Relationship	Phone Number

How did you hear about us?

☐ Family/Friend ☐ Insurance ☐ Internet/Website ☐ Location/Drive By ☐ Community Event ☐ Other: _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR (under 18)

Responsible Party First Name	Last Name	Relationship to Patient	Middle Initial	Date of Birth	Age

Sex: (check one) ☐ Male ☐ Female	Social Security #	Mobile Number	Alternate Number	Driver's License

INSURANCE & SUBSCRIBER INFORMATION

PLEASE PROVIDE ALL INSURANCE CARDS TO THE FRONT DESK

Primary Insurance	Member ID/Policy Number	Group Number	Employer

Policy Holder's Name	Date of Birth	Relationship to Patient

PATIENT PORTAL

To ensure better service, we provide online services that allow patients to conveniently make appointment requests, view lab results, review their vitals, and obtain other helpful patient information. We highly recommend this complimentary service. Please indicate below if you wish to receive information through our **Patient Portal**:

☐ **YES, I DO** wish to communicate using the secure Patient Portal system that is designed to keep my information safe. I understand I will be notified via email when there is secure information for review.

☐ **NO, I DO NOT** wish to participate in the Patient Portal

Signature _____	Email

CONSENT TO TREAT

I hereby authorize employees and agents of CPFC (including physicians, physician assistants, nurse practitioners and other staff members to render medical evaluations and care to the patient indicated below. I understand that a physician assistant/nurse practitioner is not a doctor. I also understand that a physician assistant/nurse practitioner is a graduate of a certified training program and is licensed by the State Board. Under the collaboration of a physician, a physician assistant/nurse practitioner can diagnose, treat, and monitor acute and chronic diseases, as well as provide health maintenance care. Supervision does not require the physical presence of a supervising physician. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Signature of Patient, Parent, or Legal Guardian _____ Date: _____

Printed Name of Legal Guardian (if patient is minor) _____ Relationship to patient:_____

I, the undersigned hereby consent and grant permission to Champions Point Family Clinic, LLC, Raquel Torres, DNP, FNP-C and its employees to perform tests, treatments and any procedures for the above or myself named minor.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made, whether to me or on my behalf, to Champions Point Family Clinic, LLC, Raquel Torres, DNP, FNP-C for any services to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any signature request that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approval claim forms or electronically submitted claims, my signature authorize releasing of the information to the insurer or agency shown in Medicare assigned cases, the supplier agrees to accept the coverage determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient, Parent, or Legal Guardian _____ Date:_____

Champions Point Family Clinic 5367 W. Richey Rd. Houston, TX 77066

P: 281-895-3008 F: 832-705-8941

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. Your clear understanding of the Patient Financial Responsibility Policy is an important part of our professional relationship and payment is part of that relationship. It is your responsibility to notify our office if any patient information changes (i.e.: name, address, telephone, insurance information, etc. Please review each policy below and initial:

	1. Insurance Services – Champions Point Family Clinic is a participating provider for many health plans. As a courtesy to our patients, we will file claims with these companies. It is ultimately your responsibility for the full and timely payment on your account. We will attempt to verify coverage and benefits prior to your visit. If we are unable to verify benefits, we may ask you to pay in full or reschedule your visit until 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 of coverage or payment. If your health plan denies any part (or the entirety of your claim), you agree that you are financially responsible for the balance**.**
	2. Insurance Consent - I hereby consent to the release of medical information (self, child/dependent, or family member) to the insurance companies responsible for my care. I understand that while my medical records are confidential, information within these records may be required by my insurance company in order facilitate care and will only be released at their request. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, for the purpose of healthcare operations (including but not limited to, provider review function, claims payments, and quality assessment.
	3. Co-payments and Deductibles – Co-payments and deductibles must be paid for at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles can be considered fraud. For deductible plans, it is our policy to collect $100 at the time of service. We will bill you if there is an amount due after services have been rendered, or we would apply a credit to your account if the amount paid exceeds the amount incurred on the date of service. Refunds can be requested in writing and will be paid out ONLY after any previous balances on the account have been settled.
	4. NSF Checks – We charge a $35 fee to your account if your check is returned by your bank. Upon notification from our office of your returned check, payment of the entire balance is due immediately. We accept payment in the form of credit card, cash, or money order.
	5. Claim Denials - Certain office products, procedures or services may not be covered by your health plan. You are responsible for payment of these services and will be billed if we obtain a denial from your insurance company and/or we have not received payment from the insurance company within 60 days of our filing your claim. The balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits and reduce the possibility of a denied claim.
	6. No Show/Cancellation Policy - It is important to be present at the date and time of your appointment. Patients who do not show up for their appointment or cancel less than 24 hours in advance of their appointment time may be subject to a "No Show/Cancellation" fee of $25. Please call us at least 24 hours in advance if you need to move your appointment time or date to avoid the $25 fee. It is the responsibility of the patient to inform the office if they will not be able to make their appointment. We will allow up to three (3) missed appointments or cancelled appointments that have not been rescheduled, before the patient will be charged a "No Show/Cancellation Fee". This must be paid before being able to be seen again at the clinic.
	7. Past Due Accounts/Non-Payment – It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to a collection agency which may adversely impact your credit score. We reserve the right to dismiss a patient for non-payment as from Champions Point Family Clinic. If this occurs, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our provider will only be able to treat you on an emergency basis.
	8. Self-Pay Accounts – Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the practice does not participate, or patients without an insurance card on file. If you do not have insurance, or if we cannot verify your plan prior to your visit, payment in full is expected at the time of service.
	9. Minors – The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements.

ADMINISTRATIVE SERVICES FEE POLICY OVERVIEW

Each day we strive to exceed expectation of you, our valued patients, through excellent medical care and exceptional service. To assist us in achieving our goal of exceptional service, we have adopted an administrative fee policy. Our fee is **$25 per each form/signature** with an additional **$10 fee** for all expedited forms. The fee covers all expenses related to administrative services as listed below:

- The fee is per each form/signature
- Must be paid at the time of service, prior to the forms being completed
- Is not billable to your insurance carrier
- By law, we have 15 days to complete the form and get it faxed, except for all expedited forms

Administrative Service Listing:

- Employee completed forms
- FMLA forms
- Disability forms
- Return to work forms
- Other forms requiring manual completion and which signature is required

Champions Point Family Clinic 5367 W. Richey Rd. Houston, TX 77066

P: 281-895-3008 F: 832-705-8941

CONSENT AND REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Probability Act of 1996 (HIPPA), I have the certain rights to privacy regarding my Protected Health Information (HIP). I hereby give my consent for Champions Point Family Clinic to use and disclose Protected Health Information (PHI) about me. I understand that this information can be or will be used to carry out treatment, payment, health care operations (TPO).

I have the right to review such Notice of Privacy Practices prior to signing this consent. The notice. Of privacy practices is displayed in the waiting room and a hard copy has been made available to me. I understand that Champions Point Family Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Champions Point Family Clinic 5367 W. Richey Rd. Houston, Tx 77066.

With this consent, Champions Point Family Clinic may call my home or other alternative location and/or in person about any items that assist the practice in carrying out TPO, such as: appointments reminders, insurance items, any calls pertaining to my clinical care, and laboratory results among others. Champions Point Family Clinic may mail to my home or other alternative location any items that assist the practice in carrying out healthcare operations such as: appointment reminder cards and patient/insurance statements.

I understand that I have the right to request in writing that Champions Point Family Clinic restrict how it uses or discloses my PHI to carry out my TPO. However, the practice is not required to agree to my requested restrictions, but if Champions Point Family Clinic does agree, then it is bound to abide such restrictions. I understand that I may revoke this consent in writing at any time, except to that extent that Champions Point Family Clinic has taken action relying on this consent.

I understand that by signing this form, I have read and agree with the information given to me by this practice.

Signature of Patient, Parent, or Legal Guardian _____ Patient DOB: _____

Printed Name of Legal Guardian (if patient is minor) _____ Date: _____

CONSENT AND USE FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. CONSENT

Champions Point Family Clinic may leave a message on your voice mail. If permission granted, please INITIAL to confirm:

Yes: _____ No: _____ N/A: _____

I give consent to Champions Point Family Clinic, the physicians, and other personnel on its medical staff, to administer such care, procedures, medical evaluation, minor surgery evaluation and/or treatment and diagnosis. This authorization includes hospital admission if such is deemed necessary by the physician.

I understand that the authorized person(s) will be required to furnish proof of their identity when making an inquiry. I understand that this authorization will remain in force in its entirety until it is replaced by a new signed agreement by me. I hereby authorize Champions Point Family Clinic to disclose my Protected Health Information (PHI) to the following individual(s) below.

☐ I Authorize to MYSELF ONLY (Please Check)

1. Authorized Person: _____ Relationship: _____ Telephone #: _____
2. Authorized Person: _____ Relationship: _____ Telephone #: _____
3. Authorized Person: _____ Relationship: _____ Telephone #: _____

Further Instructions:

II. ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Champions Point Family Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I acknowledge and understand that this authorization will be kept in my medical record and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify CPFC in writing should I wish to change one or more of the telephone numbers and/or contacts listed above. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Legal Representative for Patient: _____ Date Signed: _____

Print Name of Legal Representative for Patient (if applicable): _____ Relationship: _____

FOR OFFICE USE ONLY- PRIOR TO SCANNING/ FILLING THIS FORM

☐ I was able to obtain written consent for both Roman Numeral I and II from this patient. Staff Initials: _____

☐ I was unable to obtain written consent for Roman Numeral _____