

**NEW PATIENT INFORMATION
TEXAS HILLS URGENT CARE CENTERS**

PLEASE PRINT LEGIBLY

Reason for today's visit: _____

If this is an injury, is it work related? YES NO

If this is an injury, is it a result of a motor vehicle accident? YES NO

Are your symptoms related to a dental problem, toothache or abscess? YES NO

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone number: Home _____ Cell _____ Work _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address (if Different) _____ City _____ State _____ Zip _____

Patient EMPLOYER INFORMATION:

Name of Company _____ Phone number _____
Address: _____ City _____ State _____ Zip _____

RESPONSIBLE PARTY INFORMATION: (if different from above)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone numbers: Home _____ Cell _____ Work _____
Mailing Address: _____ City _____ State _____ Zip _____
Relationship to the patient: _____
Name of Employer: _____ Phone number _____
Address: _____ City _____ State _____ Zip _____

INSURANCE POLICY HOLDER INFORMATION: (if different from responsible party)

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: _____ Gender: M F Social Security #: _____ Marital Status: _____
Phone numbers: Home _____ Cell _____ Work _____
Mailing Address: _____ City _____ State _____ Zip _____
Relationship to the patient: _____
Name of Employer: _____ Phone number _____
Address: _____ City _____ State _____ Zip _____

*****Please give us the name of an Emergency Contact:**

Name: _____ Phone#: _____

I certify that the information provided above is complete and accurate to the best of my knowledge.

Signature of Patient or Patient Representative

Date

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Our office would like to have an open line of communication with you. We often send out satisfaction surveys so that we can learn how to better serve the public, seek ways to improve our services, and learn what we are doing well. We may also send out a newsletter with updates and valuable health related information. We also use a secure HIPAA compliant service through **RELAY HEALTH** to allow patients to communicate with our nurses and lab technicians as well as allow patients the opportunity for online **WEB VISITS** with Dr. Michael Dickey for simple illnesses like sinusitis, ED medications and consultations, allergy related illnesses etc.

Please provide an email address so that we can better communicate with you.

EMAIL ADDRESS: _____

How did you hear about our clinic?

- RADIO NEWSPAPER SPORTS PROGRAM TELEVISION WEBSITE DRIVE BY
- BILLBOARD FAMILY/FRIEND MY DOCTOR LOCAL BUSINESS PHONE BOOK
- OTHER _____ (PLEASE SPECIFY)

Thank you for using our clinic for your health care needs.

PATIENT NAME: _____

DATE OF BIRTH: _____

**OFFICE POLICIES
TEXAS HILLS URGENT CARE CENTERS**

Thank you for choosing our office to provide your urgent medical care. We appreciate your trust and look forward to working with you. In order to better serve you, we ask that all of our patients read and sign our OFFICE POLICIES. If you have any questions, please feel free to ask.

1. **VERIFYING INSURANCE COVERAGE:** As a courtesy to you, we will verify your insurance for eligibility benefits when you arrive to our office. We will check for any deductibles, coinsurance, copayments and coverage of any other service that may be pertinent to your treatment. You are ultimately responsible for knowing if there are any non-covered services, deductibles or special policy provisions specific to your plan. You will be responsible for paying any deductible, coinsurance, copayment or non-covered service today.
2. **PAYMENT:** Payment is due at the time of service. Additionally, if you have a balance following an insurance payment for a previous visit, you will be expected to pay that amount as well. Balances sent to collections will be collected prior to seeing the doctor today.
3. **INSURANCE INFORMATION:** **New insurance** coverage as well as **any changes in insurance** must be provided at the time of your visit. Failure to provide correct and current insurance information will result in the entire bill being YOUR responsibility.
4. **CHANGES IN PERSONAL INFORMATION:** Any changes in your marital status, address, or telephone number must be provided to our office to ensure our records have accurate and current information.
5. **BALANCES:** If your account balance exceeds 30 days from the 1st statement, a minimum one time late fee of \$7.50 or 5% (greater of the two) is placed on your bill in addition to the overdue balance. If payment is made in person or over the phone within 10 days of the statement date, the late fee will be removed. If your account is turned over to a collection agency, a collection fee (currently 35% of the balance) will be added to your account balance. The collection agency will report any unpaid balance owed to major credit bureaus. Our office will not remove any credit record reporting that was placed on your credit report even after payment is made.
6. **RETURNED CHECKS:** There will be a \$30 fee for all returned checks or payments stopped after services are paid for. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card or prosecution through the District Attorney’s office will be authorized.
7. **MINIMUM OFFICE VISIT CHARGE:** If you have been checked in, triaged (vital signs taken, history of present illness documented, etc) by a nurse, and are put into a room to be seen by a physician, and you choose to leave without being seen by a physician, you will be charged a minimum nurse visit charge plus the cost of any tests performed. Nurse visit charges are currently \$40 for established patients and \$70 for new patients. Insurance copayments and deductibles will apply.
8. **PRESCRIPTION REFILLS:** Refills for medications prescribed by our physicians will not be refilled by our office. If a refill of a prescription is requested, you must be re-evaluated by a physician, or discuss the need for a refill of the medication prescribed, or must obtain further refills from your primary care physician.

Thank you for reading this information in full. Please sign below to acknowledge your understanding of our OFFICE POLICIES. Please keep one copy for yourself for future reference.

Patient or Responsible Party Signature

DATE

PATIENT NAME: _____

DATE OF BIRTH: _____

TEXAS HILLS URGENT CARE CENTERS

Please read the following information carefully!

Our office is independently owned and operated. We do not receive any government funding or subsidies to provide care to the public. Our office employs highly trained and educated staff and physicians in order to provide the highest quality and courteous care to our patients. We do our best to inform you of your financial responsibility and expect that payment from our patients be made today. If you do not have the intention of paying the amount of money determined to be your responsibility for services received today, do not sign this form and seek treatment elsewhere.

PAYMENT POLICY: If an insurance company that we are contracted with insures you, we will be verifying eligibility and benefits at the time of service. If you have a deductible that has not been met, office copay, or your plan requires you to pay a percentage of your visit (coinsurance), we will be collecting that amount today at the end of your visit. You must have a **CURRENT** insurance card present at the time of service. You must present this card to receive your insurance benefits. An inability to present a current insurance card will require that you pay for your office visit in full today. **UNINSURED AND OUT-OF-NETWORK INSURED PATIENTS:** Marble Falls Minor Emergency Center and Hill Country Urgent Care requires **PAYMENT IN FULL** at the time of service for patients whose insurance plans we do not accept. Our office also requires **PAYMENT IN FULL** for those patients who are uninsured. We offer at 25% discount on our billed charges if either of the above mentioned circumstances exist. **We reserve the right to file theft of service charges in the event you are unable to meet this obligation once you have received your medical treatment. Theft of Service is a CRIME. Our office accepts major credit cards, personal checks, and cash. We do not hold checks or accept postdated checks. If your check cannot be directly debited through TELECHEK today, you must have another form of payment available to avoid being prosecuted for theft of service.**

CONSENT FOR MEDICAL TREATMENT: I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to procedures and care and to the medical, surgical, or other services given to me under the specific instructions of any physicians working in this facility, as necessary in their judgment. **I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as a result of the treatments or examination by our physicians.**

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with the insurance company listed or given to our office, and assign directly, all insurance benefits, if any, otherwise payable to MFMEC or HCUC for services rendered. I understand that I am financially responsible for all charges, whether or not paid for by insurance. I authorize my signature on all insurance submissions.

The physicians at the Marble Falls Minor Emergency Center and Hill Country Urgent Care may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services. This consent will end 1 year from the date signed below.

HOW WILL YOU BE PAYING FOR TODAY'S OFFICE VISIT?

CASH CHECK CREDIT CARD EMPLOYER

Your signature below is an acknowledgment that you have read, understand and agree to the terms of payment policy, consent for medical treatment, and insurance assignment and release.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

PATIENT NAME: _____

DATE OF BIRTH: _____

**TEXAS HILLS URGENT CARE CENTERS
NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT**

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provided in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice’s legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - * The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions against me in the event of such a complaint.
 - * The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
 - * The right to receive confidential communications of protected health information.
 - * The right to inspect and copy protected health information.
 - * The right to amend protected health information.
 - * The right to receive accounting of disclosures of protected health information.
 - * The right to obtain a paper copy of the Notice of Privacy Practices upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain these practices current Notice of Privacy Practices on request.

Signature

Date

Relationship to patient (if signed by a personal representative of the patient).

TEXAS HILLS URGENT CARE CENTERS

**MARBLE FALLS MINOR EMERGENCY CENTER
1701 HWY 281 N.
MARBLE FALLS, TX 78654
830-798-1122**

**HILL COUNTRY URGENT CARE
13917 HWY 71 W.
BEE CAVE, TX 78738
512-263-1600**