

Marble Falls Minor Emergency Center
1701 Hwy 281 N * Marble Falls, Texas 78654
830/798-1122 (phone) 830/798-1124 (fax)

PLEASE PRINT

If this is an injury, did it occur at work? Yes / No

Have you reported this injury to your employer? Yes / No

PATIENT INFORMATION:

Last Name: _____ First Name: _____
Birthdate: _____ Gender: male / female Soc Sec #: _____
Home Phone: _____ Cell Phone: _____
Street Address: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Marital Status: _____
Emergency Contact: _____ Phone: _____
Employer: _____
Address: _____ City: _____ State: _____
Zip: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION: (please complete for minor patients)

Last Name: _____ First Name: _____
Birthdate: _____ Gender: male / female Soc Sec #: _____
Home Phone: _____ Cell Phone: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Marital Status: _____ Relationship to patient: _____
Employer: _____
Address: _____ City: _____ State: _____
Zip: _____ Phone: _____

INSURANCE POLICY HOLDER INFORMATION:

Last Name: _____ First Name: _____
Birthdate: _____ Gender: male / female Soc Sec #: _____
Home Phone: _____ Cell Phone: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Marital Status: _____ Relationship to patient: _____

I certify that the information provided above is complete and accurate.

Signature

Date

**MARBLE FALLS MINOR EMERGENCY CENTER
1701 HWY 281 N
MARBLE FALLS TX 78654**

**STOP!!! YOU MUST READ THE FOLLOWING INFORMATION CAREFULLY
BEFORE BEING SEEN AND INITIAL EACH BOX.**

INSURED PATIENTS 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, an 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. **We reserve the right to prosecute for theft of service 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 post dated 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. 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 the current insurance card will require that you pay for your office visit in full today.

UNINSURED AND OUT-OF NETWORK INSURED PATIENTS PAYMENT POLICY: Marble Falls Minor Emergency Center 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 20% discount on our billed charges if either of the above mentioned circumstances exist. **We reserve the right to prosecute for theft of service 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 post dated 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 such procedures and care and to such medical, surgical, or other services under the specific instructions of Dr. Michael W. Dickey, Dr. Paul Carstens, Dr. Stephen Little, or any physician working in this facility, as necessary in his judgment.

I also acknowledge that the practice of medicine is not an exact Science and that no guarantees have be made to me as a result of the treatments or examination by Drs. Little, Dickey, Carstens, or other 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 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 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**

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

INITIALS DATE

PRINTED NAME OF PATIENT

PATIENT'S DATE OF BIRTH

MARBLE FALLS MINOR EMERGENCY CENTER
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MARBLE FALLS, TX 78654
830-798-1122

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

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 is 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 this practices current Notice of Privacy Practices on request.

Signature

Date

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

Confidential Communication Request

I would like to receive communications of my protected health information (lab results, test results, etc.) from this practice by:

US POSTAL SERVICE

I acknowledge that the address currently on file is correct and valid.

PHONE CALL

I acknowledge that the phone number (s) on file are correct and valid.

Signature

Date

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