Linda Carney MD - AllMedPhysicians, pLLC – Primary Care Extraordinaire

PATIENT REGISTRATION INFORMATION

Patient Information:

Patient's Legal Last Name	Patient's Legal First Name	Middle Name	Nick Name
M / F Gender	Date of Birth (MM/DD/YYYY)	Social Security Number	Drivers License Number
Patient's Street Address			Patient's Home Phone
Patient's City	State	Zip Code	Patient's Cell Phone
Patient's Race	Patient's Primary Language	Patient or Parent's Email For Patient Portal Communications	
Patient's Employer / School		Full-Time Part-Time Self Circle One	Patient's Work Phone
Patient's Employer Address		Position	

Emergency Contact:

Contact Name	Relationship to Patient	Cell Phone	Emergency Contact's Employer
			Alternate Phone

Primary Insurance and Policy Holder Information:

Insurance Company Name	Policy Holder's Legal Last Name	Legal First Name	Middle Name
M / F Gender	Date of Birth (MM/DD/YYYY)	Social Security Number	Policy Holder's Home Phone
Policy Holder's Street Address, City, State, Zip			Policy Holder's Work Phone

Check any/all that apply:

___ I am the Policy Holder and the Guarantor. (Guarantor is an adult completing form for themselves, or for a minor.)
___ I have secondary insurance. (Please fill out Page Two)
___ I am the Guarantor but not the Policy Holder (Please fill out Page Two)
___ Patient is under 18 years of age. (Please fill out Page Two)

I request that payment of authorized insurance benefits be made on my behalf to AllMedPhysicians, pLLC for any services furnished. I authorize AllMedPhysicians to release to the insurance company listed above any medical information about me or my dependent which may be needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original until revoked in writing. I understand that I am financially responsible for all charges whether or not covered by insurance and that it is my responsibility to know if Linda Carney MD / AllMedPhysicians, pLLC is "In-Network" for my insurance policy. In addition, I am hereby notified that if I do not show for a scheduled appointment, or fail to cancel an appointment, with 24 hours notice, a no show will be noted on my account, and I may be charged a fee of $25.00 since AllMedPhysicians requires a 24-hr notice for all cancellations or reschedules. With three **(3)** no shows, I may be terminated from the practice at AllMedPhysicians.

I understand that this office holds my medical records in strict confidence. They will not be released to anyone without my explicit written permission. All requests for the release of medical records must be in writing. A reasonable fee may be charged by this office for the issuing of medical records. By signing below, I acknowledge that I have been offered a copy of the notice of HIPAA privacy practices from AllMedPhysicians, pLLC.

Signature of Patient / Guarantor (circle one) | **Date Signed** (MM/DD/YYYY)

How did you hear about us? ____

Do you have a relative or friend who is a part of our practice? ________ If so, who? ______________________________

___ If you have secondary insurance, complete the box below:

Secondary Insurance:

Insurance Company Name	Policy Holder's Legal Last Name	Legal First Name	Middle Name
M / F Gender	Date of Birth (MM/DD/YYYY)	Social Security Number	Drivers License Number

Please Note: If the policy holder for the secondary insurance policy is the same as the primary insurance policy holder you do not have to fill out the information below.

Policy Holder's Street Address			Policy Holder's Home Phone
Policy Holder's City	State	Zip Code	Policy Holder's Cell Phone
Policy Holder's Employer			Policy Holder's Work Phone
Policy Holder's Employer Address		Position	

___ If you are the Guarantor but not the Policy Holder, complete the box below:
Guarantor Information: The guarantor is the adult patient who completes this form or the adult accompanying a minor patient today.

Guarantor Information:

Guarantor's Legal Last Name	Guarantor's Legal First Name	Middle Name	
M / F Gender	Date of Birth (MM/DD/YYYY)	Social Security Number	Drivers License Number
Guarantor's Street Address			Guarantor's Home Phone
Guarantor's City	State	Zip Code	Guarantor's Cell Phone
Guarantor's Employer			Guarantor's Work Phone
Guarantor's Employer Address		Position	Guarantor's Email

___ **MINOR CHILD AGREEMENT**: I understand that an adult over age of 18 must accompany each pediatric patient until the visit is completely over. I also agree that Dr Carney and her staff will communicate with me and provide 1 copy of records to me if I request them and I am responsible for communicating these results to any other interested party, including a custodial parent who is not signing this form. The office staff of AllMedPhysicians, pLLC will make every reasonable attempt to notify me or the custodial parent/guardian when the minor presents to the clinic for treatment without adult supervision. If the patient presents by herself/himself to this office for care, I understand that I am also authorizing that care and I accept financial responsibility for it.
Below is a list of adults who may bring my child here for medical services and sign for financial responsibility.

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________________________ ______________________

Signature of Patient / Guarantor (circle one) **Date Signed** (MM/DD/YYYY)

AllMedPhysicians, pLLC

MEDICATION CHART

Patient Name: ________________________________

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Name of medicine	Dose (total mg)	How many times per day?	When is it taken? (Morning and night? After meals?)	Who prescribed it? (Physician's last name)	Why do you take it?	Do you have any side-effects? Describe them.
Prescriptions						
Over-the-counter medications, herbal remedies, vitamins						

WHICH LOCAL PHARMACY DO YOU USE? ________________________________

WHICH MAIL ORDER PHARMACY DO YOU USE? ____________________________

Linda Carney, MD / AllMedPhysicians, pLLC / Primary Care Extraordinaire / 1760 FM 967, Ste B, Buda, TX 78610
Phone: (512) 295-7877, Fax: (512) 295-4777, Web Site: http://www.AllMedPhysicians.com

AllMedPhysicians, pLLC

DISCLOSURE OF PATIENT RECORDS

The HIPPA privacy act gives patients the right to request a restriction on the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that the communication of PHI can be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The following is a list of choices for you to determine how your protected health information can be used or shared:

I wish to be contacted in the following manner:

Home Phone	Cell Phone	Work Phone	Other Phone
___ Detailed Message OK ___ Call back number only	___ Detailed Message OK ___ Call back number only	___ Detailed Message OK ___ Call back number only	___ Detailed Message OK ___ Call back number only
Please note that marking All your phone numbers as "Leave call back number only" could impact patient care by preventing us from leaving important messages in a timely manner.			**What/Who is other phone number:** ___________________________ ___________________________

Written Communications will automatically be sent to your home address (i.e. Lab results, correspondence) unless otherwise indicated below:

☐ **I wish for my PHI to be mailed to a place other than my home:**

____

Addressed to:

____

Street Address/PO Box/Apt. or Unit Number

____

City **State** **Zip**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made with the authorization requested by the individual.

I hereby give the office my permission to release any necessary information to the following individuals listed below should they call on my behalf:

Name of individual:	Relationship to patient:
____________________________	_________________________
____________________________	_________________________
____________________________	_________________________

This information may be revoked or changed at any time by filling out a new form.

____ ________________

Patient/Guarantor Signature **Date**

____

Print Patient Name

HIPAA Release

Notice of Privacy Practices, pursuant to the HIPAA regulations

I acknowledge that I have been offered (my own copy to keep for myself) the notice of privacy practices in effect at AllMedPhysicians, pLLC and have been made aware that this same notice is posted in the lobby here.

Signature ____ Date ________________________________

Linda Carney, MD/AllMedPhysicians, pLLC

FINANCIAL POLICY

Linda Carney MD/AllMedPhysicians, pLLC believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement form our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

   Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self pay patients.

3. **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.

4. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Hays County.

5. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **FORMS FEES:** completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records is $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. AllMedPhysicians, pLLC will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

7. **BILLING OFFICE:** If you have questions in regard to any of your billing statements, our accounts receivable staff at **Healthy Images Billing** is available to assist you. **CALL 512-295-6980.**

8. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.

9. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to **LINDA CARNEY MD/AllMedPhysicians, pLLC** for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BEBEFITS:** I hereby assign, transfer, and set over directly to **LINDA CARNEY MD/AllMedPhysicians, pLLC** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Linda Carney, MD /AllMedPhysicians, pLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Linda Carney, MD /AllMedPhysicians, pLLC. I authorize Linda Carney, MD /AllMedPhysicians, pLLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **INSURANCES WE WON'T BILL/PATIENTS WE WON'T ACCEPT INTO THE PRACTICE:** I am not currently eligible for Medicare, Medicaid, TriCare or CHAMPUS. I will notify Dr. Carney in writing immediately if I become eligible for these payors, thus terminating my care from AllMedPhysicians, who WILL NOT accept new patients with Medicare, Medicaid, TriCare or CHAMPUS nor bill these payors if patients switch after becoming established with AllMedPhysicians, pLLC..

12. **SELF PAY PATIENTS OR PROMPT PAY PATIENTS WHO ARE INSURED:** A 20% prompt pay discount is applied to all full pay payments received at the time of service whether or not you carry insurance. This means anyone willing to/or needing to pay in full at the time of service will receive the 20% discount off of the evaluation and management service codes only. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. AllMedPhysicians, pLLC does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service. By signing below I state that I am not eligible for Medicaid or Tricare and will never ask this office to bill them.

13. **RELEASE OF INFORMATION:** I hereby authorize the and direct **LINDA CARNEY MD/AllMedPhysicians, pLLC** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

14. **COLLECTION FEES:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

15. **DIVORCED PARENTS of PATIENTS:** By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

____ ____________________
Signature of Patient (or Guarantor, if applicable) Date

____
Please print the name of the patient

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