**University Physicians Group**

A member of the Seton Family of Doctors

**PATIENT INFORMATION:**

First Name:_____ M.I._____ Last Name_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address: _____

Date of Birth:_____ Sex: F M SSN:_____ Marital Status:_____

Ethnicity:_____ Race: _____ Language: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Care Physician:_____ Phone:_____ Fax: _____

Referring Physician: _____Phone: _____ Fax: _____

**RESPONSIBLE PARTY**

First Name:_____ M.I._____ Last Name_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Date of Birth:_____ Sex: F M SSN:_____ Relationship:_____

Email Address: _____

**PHARMACY INFORMATION**

Pharmacy Name: _____ Location: _____ Phone: _____

**PRIMARY INSURANCE INFORMATION**

Insurance Company:_____ Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder Phone:_____ Relation to Patient: _____

**SECONDARY INSURANCE INFORMATION**

Insurance Company:_____ Policy Holder Name:_____

Policy Holder DOB:_____ Policy Holder Phone:_____ Relation to Patient: _____

**REFERRAL SOURCE (Please Circle)**

**Newspaper TV Radio Direct Mail Magazine Website/Internet Billboard Event Friend/Family Other: _____**

**Do you have an advanced directive? (Please Circle) Yes No**

**MEDICAL INFORMATION:** I authorize the physicians of this office to release any information they have acquired in the course of me or my child's treatment to my insurance company or companies or any third party payer so that they may obtain payment for medical services rendered.

**INSURANCE AUTHORIZATION:** I hereby authorize the physicians or staff of this office to furnish information to my insurance carries concerning myself or my child's illness and treatments.

**ASSIGNMENT OF BENEFITS:** I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. **I ALSO AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.**

**Signature of Patient or Guardian: _____ Date:_____**

# Consent to Treat and Health Care Agreement

1. Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that University Physicians Group includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

I understand that this Consent to Treat will be valid for each visit I make to the University Physicians Group until revoked by me in writing.

2. Consent to Release Information

I acknowledge that University Physicians Group may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.

I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by University Physicians Group.

I acknowledge and consent to allow University Physicians Group to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

3. Assignment of Insurance Benefits/Patient Financial Responsibility

I assign and transfer to University Physicians Group all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that University Physicians Group are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.

4. Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to University Physicians Group on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

5. Lab/X-ray/Diagnostic Services

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or diagnostic services that are not provided by University Physicians Group or its employees. I also understand that I am financially responsible for any deductible, co-pay or balance due for these services if they are not reimbursed by my third-party payer for whatever reason.

6. Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

7. Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

8. Notice of Privacy Practice

I acknowledge receipt of the "Notice of Privacy Practices" from University Physicians Group.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS**

The HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

I certify that I understand the privacy risks of mail, telephone and email. I hereby authorize a representative or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, laboratory results and referral arrangements. I understand that I have the right to rescind this authorization at any time by notifying us in writing.

Name of Patient: _____ Effective Date: _____ DOB: _____

**If we need to reach you during business hours regarding test results, how may we reach you?** (check all that apply):

☐ **Home Phone:** _____

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Work Phone:** _____

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Cell Phone:** _____

- ☐ Leave a message with detailed information
- ☐ Leave a message with call back number only
- ☐ If emergency, contact me at this number

☐ **Written Communication:**

- ☐ Mail to home address
- ☐ Mail to alternate address (see below)

Alternate Address: _____

City/Town, State: _____ Zip Code: _____

**I give permission to send test results via secure encrypted email:** Yes ____ No ____

E-mail address _____

**I give permission to disclose and discuss any information related to my medical condition(s) to/with the following:**

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

Patient Signature _____ Date _____

Parent/Legal Guardian _____ Date _____