117 Jane Lane
Hillsboro, Texas 76645
Phone (254) 582-8006 Fax (254) 582-8013

Thank you for choosing us for your healthcare needs. We would appreciate if you would complete this form to help us with your referral source.

Name: ______________________________

Date: ______________________________

Physician Seen today: Dr. ______________________

Please check how you heard about us:

Word of Mouth___ Direct Mail___ Healthy Women___ Senior Circle___ Newspaper Article___
Newspaper Ad: The Reporter ___
The Lakelander ___
The West News ___
Hubbard City News ___

Other: ______________________________

Are you a member of the: Senior Circle Y N
Healthy Women Y N

To help us improve the way we care for our patients and help ensure you understand the physician's care instruction, we will make a brief random follow up call to some of our patients. If your name is selected would you be okay in receiving a follow up call. Please mark below.

Yes ___ No ___

Contact source: Home phone ___ Cell ___ Work ___ Other______________

Email address: ______________________________

Preferred Pharmacy: ______________________________

We thank you and look forward to taking care of your healthcare needs now and in the future.

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PATIENT INFORMATION

NAME ____
(First) (Middle) (Name)

Mailing Address: ____
(street/Apt./P.O. Box) (City) (state) (Zip code)

Gender: __male __female **Employed:** __Yes __No

Employer's Name and Address ____

Occupation ____

Telephone: (Home) ____________________ **(Work)** ____________________

(Cell.) ____

Date of Birth ____________________ **Social Security** ____________________

Marital Status: ___Single ___Married ___Separated __Divorced ___Widow/Widower

BILLING INFORMATION

Person responsible for paying bill: __ Patient __Parent __Spouse __Other: ____________

Name (if different from above) ____________________ Date of Birth____________

Address (if different from above)____

Telephone: (Home) ____________________ **(Work)** ____________________

(Cell.) ____

Occupation ____

Employer's Name and Address ____

INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance
Insurance Co		
Address		
City/State/Zip		
Telephone		
Subscriber I.D.		
Group#/Name		
Policyholder		
Social Sec. #		

Policyholer: __self __spouse __child __other: **Date of Birth of Subscriber:** ____________

Person to be contacted in case of emergency

Name ____ Relationshhip: ____________

Telephone: ____

Is this visit about an accident? Yes___ No___ . **If so, indicate:** Auto___ Worker's Comp___ Other___

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

Financial Agreements (initial)

_____ I have no insurance coverage. I understand that I am responsible for payment of services rendered to myself or my dependents **at the time of service.**

_____ I understand if I fail to pay amounts owed; the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting-agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

Insurance Authorization and Assignment (initial)

_____ I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ I understand I am responsible **at the time of service** for paying any required co-payment and/or deductible.

Medicare

For Medicare Patients Only **Medicare Number** ______________________________

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

There will be a $25.00 charge on all returned checks.

I have read and understand the payment policy of this office and agree to abide by the said policy.

____ ______________________

Patient/Parent/Guardian Date

Please present both your insurance card and your driver's license so we may make a copy for our records.

117 JANE LN
HILLSBORO, TX 76645-2673
Phone: (254) 582-8006 Fax: (254) 582-8013

General Consent to Treatment:

Having come to ____(Provider) for evaluation or treatment, I (or my authorized representative on my behalf) hereby consent to and authorize Provider and other staff members involved in my care to administer such diagnostic procedures, treatment or both as they may consider advisable to maintain my health and to assess and to evaluate and treat my injury or illness. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, the benefits and the most common risks involved in the diagnosis and treatment of my illness or injury, as well as alternative available courses of treatment, and I understand that I have the right to refuse any suggested examination, test or treatment.

Right to Refuse Treatment:

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

____

Patient/Authorized Representative Signature

____

Patient/Authorized Representative Printed Name

____

Date

PHI DESIGNATED CONTACT LIST

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, patients have the right to agree, restrict or object to providing PHI (protected health information) to family members, friends and/or other persons identified as involved in the patient's care or responsible for payment of the patient's health care.

To comply with the regulations, as outlined in the CHS HIPAA Privacy Policy documentation of the patient's wishes must be present in the medical record.

Unless you object, PHI can be verbally disclosed to those individuals listed below for medical purposes. Your signature also authorizes our staff to update this list per your discretion.

____________________________ ____________________ ________

Signature Relationship Date

Please list all individuals that you authorize for verbal disclosure of medical information.

Spouse	______________________	Phone	______________
Significant Other	______________________	Phone	______________
Child	______________________	Phone	______________
Child	______________________	Phone	______________
Mother	______________________	Phone	______________
Father	______________________	Phone	______________
Sibling	______________________	Phone	______________
Sibling	______________________	Phone	______________
Grandparent(s)	______________________	Phone	______________
Grandparent(s)	______________________	Phone	______________
Other	______________________	Phone	______________
Other	______________________	Phone	______________

Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

Parent, Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name		
Patient Signature	Date	Time

☐ Patient Refused Access to the Portal

Clinical Staff Signature (witness to refusal)	Date	Time

Patient Label

Timberland Medical Group
d/b/a
Hill Family Medicine

Acknowledgment of Receipt of Privacy Practices

Attached please find this facility's Notice of Privacy Practices. Your name and signature on this cover sheet indicates you have received a copy. The Notice is yours to keep.

If you have any questions, you can contact our Facility Privacy Officer at (254) 580-8962.

I hereby acknowledge that I have been provided with a copy of this facility's Notice of Privacy Practices.

Patient's Signature or Legal Representative	Date	Time

Relationship to Patient	Interpreter, if utilized
Witness Signature	If Telephone Consent, Second Witness Signature