

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

SATIR AND SATIR, P.A.
4942 NE STALLINGS
NACOGDOCHES, TEXAS 75965
936-560-9595

Patient Information
Pediatric Patient

WELCOME TO OUR PRACTICE!

Patient Name: _____

If Patient is a minor, List Mother and Father: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) ____-____ Cell: (____) ____-____

DOB: ____/____/____ Age:____ SS#:____/____/____

Gender:____ Race:____ Marital Status: _____

Place of Employment: _____

Work Phone: (____) ____-____

Insured Party: _____ Insured DOB: _____

Emergency Contact Name: _____

Relationship to patient: _____

Phone Number: (____) ____-____ DOB: ____/____/____

(If different from above)

Person Responsible for payment of the account: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) ____-____ Cell: (____) ____-____

DOB: ____/____/____ Age:____ SS#:____/____/____

PLEASE LIST PHARMACY THAT YOU PREFER:

It is our pleasure to serve you. If you have any questions, please do not hesitate to ask. Thank you.

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ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Satir and Satir, P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Satir and Satir, P.A. to: 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) to process insurance claims generated in the course of examination or treatment; and 3) to allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Satir and Satir, P.A. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient/Responsible Party Signature

Date

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PATIENT FINANCIAL POLICY SHEET

In order to reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment (for the patient due portion of the service) is due at the time of service. For your convenience we accept VISA and MasterCard. Payment for co-pays will be taken at the time of check-in.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized deductible and co-payment at the time of service. It is the policy of our office to collect this deductible and co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim. However, each insurance company has its own version of “usual and customary” and the patient will be responsible for payment of this amount.
- In the event that your health plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

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

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date

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

HIPAA Notice of Privacy Practices

Satir and Satir, P.A.
4942 NE Stallings
Nacogdoches, Texas 75965
936-560-9595

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

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

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices: I understand that these policies are in place and will not change unless notified in writing.

Print Name: _____

Signature: _____

Date: _____

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

HIPAA Notice of Privacy Practices

Satir and Satir, P.A.
4800 NE Stallings, Suite 115
Nacogdoches, Texas 75965
936-560-9595

RELEASE INFORMATION:

1. The following people have my permission to talk to Satir and Satir and/or pick up my medical records (list names):

Or, Information is not to be released to anyone.

2. The following people have my permission to pick up my prescriptions/samples:

Or, Prescriptions/samples are not to be released to anyone.

3. The following people are authorized to bring my child for medical care. (I understand that vaccinations or therapeutic shots will not be given unless a parent accompanies my child):

Or, No one can bring my child to an appointment other than a parent.

These authorizations are good until I change them in writing.

TELEPHONE MESSAGES

Please call my home _____ my work _____
 my cell number _____

If unable to reach me:

You may leave a detailed message on my home my work my cell
 Please leave a message asking me to return your call.

Patient/Parent Signature

Date

Witness Name

Date

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

Preferred Pharmacy information:

Pharmacy Name:

Address _____ Phone _____

Race –(Please circle the information below that applies to you):

American Indian/Alaskan Native

Asian

White

Nat Hawaiian/Pacific Islander

Other

Unknown

Black/African American

Decline

Ethnicity –(Please circle the information below that applies to you):

Hispanic or Latino

Not Hispanic or Latina

Other

Preferred Communication- (Please circle the information below that applies to you):

Email

Fax

Mail

Phone

Text

Please provide preferred contact telephone number:

Please provide e-mail address:

Please circle yes or no:

Do we have authorization to call you at work: Yes No

Is it ok to leave a message on your preferred contact number: Yes No

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

Welcome To Our Practice!



BIRTH HISTORY:

Type of delivery (please circle one): csection vaginal/natural delivery

Birth weight: _____

Complications at birth? (antibiotics given, lab done, tests done?) Describe:

Hospitalizations? (list by approximate year and describe reason for hospitalization):

Has your child ever had surgery? If so, when and what kind?

Any other known medical diagnosis? _____

Patient Medication History:

Drug allergies- (list medication and reaction)? _____

List current medications (including any prescription, herbal or over the counter medications): _____

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Review of systems: (answer "yes" or "no" and on line provided include details if answered "yes"- N/A if not applicable)

Headaches? If so, how long? _____

Epilepsy? If so, when was it diagnosed? _____

Seizures with fever (febrile seizures)? If so, how many & approximate dates?

Ear infections? If so, how many? _____

Throat infections/strep throat? _____

Snoring/sleep apnea/pauses during breathing? _____

Allergy symptoms? (itchy eyes, sneezing, nose bleeds, coughing up blood)

Short of breath? (all of the time, on exertion?) _____

Chest pain/pressure? (when and how long does it last?) _____

Joint problems or achy/stiff joints? _____

Arthritis? _____

Recurrent skin/staph infections or "insect" bites? _____

Walk with a limp? _____

Constipation or diarrhea? _____

How often does your child have a bowel movement? What is "normal" bowel movement pattern for your child? _____

Problems with any of the following categories? (Answer "yes" or "no" and describe if answered "yes")

Eye _____ Nosebleeds _____

Dental _____ Skin _____

Depression/depression symptoms _____

Psychiatric _____

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Family History (especially for mom, dad, & siblings):

Diabetes? _____

Asthma? _____

Unexplained death? _____

Childhood death? Causes? _____

Death during athletic participation? _____

Childhood heart disease? _____

Cancers/pre-cancers? _____

Social History:

Any smokers in the house? _____

Does your child stay more than 1 hour/day in a house in which a person smokes?

Does your child attend day care/preschool? How long per day? _____

How many hours of television/day? _____

How many hours of video games/day? _____

How many hours of outside/physical activity? _____

With whom does the child live with (biological parents, step parents, grandparents, legal custodian)? _____

Are there pets in the house and if yes, what kind? _____

Patient hobbies: _____

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

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

I REQUEST AND AUTHORIZE (Doctor Name/Address/Phone Number):

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO

_____.

THIS REQUEST AND AUTHORIZATION APPLIES TO:

*ALL HOSPITAL RECORDS (INCLUDING NURSE RECORDS & PROGRESS NOTES)

*TRANSCRIBED HOSPITAL RECORDS

*MEDICAL RECORDS NEEDED FOR CONTINUITY

*MOST RECENT FIVE-YEAR HISTORY

*LABORATORY REPORTS

*PATHOLOGY REPORTS

*X-RAYS, MRI'S AND CT SCANS

*DIAGNOSTIC IMAGING REPORTS

*CLINICIAN OFFICE CHART NOTES

*DENTAL RECORDS

*PHYSICAL THERAPY RECORDS

*EMERGENCY & URGENCY CARE NOTES

*BILLING STATEMENTS

*ALL REPORTS

*OTHER: _____

THIS INFORMATION IS BEING REQUESTED FOR THE PURPOSE OF: _____

PLEASE RELEASE RECORDS FOR THE DATES OF: _____

I UNDERSTAND THAT MY EXPRESS CONSENT IS REQUIRED TO RELEASE ANY HEALTH INFORMATION RELATING TO TESTING/DIAGNOSIS AND/OR TREATMENT FOR HIV (AIDS VIRUS), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH OR DRUG AND/OR ALCOHOL USE. IF YOU HAVE BEEN TESTED, DIAGNOSED OR TREATED FOR HIV (AIDS VIRUS), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC DISORDERS/MENTAL HEALTH, OR DRUG AND/OR ALCOHOL USE, YOU ARE SPECIFICALLY AUTHORIZED TO RELEASE ALL HEALTH CARE INFORMATION RELATING TO SUCH DIAGNOSIS, TESTING OR TREATMENT.

SIGNATURE OF PATIENT/PATIENT'S AUTHORIZED REPRESENTATIVE DATE

RELATIONSHIP TO PATIENT: PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE

**THIS AUTHORIZATION IS VALID FOR 90 DAYS AFTER THE DATE IT IS SIGNED.
A PHOTOSTATIC COPY IS AS VALID AS AN ORIGINAL.
THIS AUTHORIZATION IS REVOCABLE AT ANY TIME.**