TEXAS HEALTH MEDSYNERGIES
PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Name: ____ Date of Birth: ____________
Last Name First Name

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Texas Health MedSynergies or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Health MedSynergies is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's records that these programs may request. I hereby direct that payment of my, or my dependent's authorized benefits be made directly to Texas Health MedSynergies or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have read and been offered a copy of the Texas Health MedSynergies. "HIPAA Notice of Privacy Practices". I hereby authorize Texas Health MedSynergies. or the physician individually to release any of my, or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Health MedSynergies representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Texas Health MedSynergies to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my Texas Health MedSynergies physician or those under his/her supervision.

PATIENT SIGNATURE:____ DATE:________________

GUARANTOR SIGNATURE:_____________________________________ DATE:________________
(if different from patient)

GUARANTOR NAME (Please Print):____

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: ______________________________ **Date of Birth:** _____________ **Date of Visit:** _____________

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, and any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Clinic to know if my insurance will pay for my Medical service or visit, Preventative exam or physical, Lab testing, X-ray, EKG, or any other Screening service or Diagnostic testing ordered by the physician or the physician's staff.

I understand and agree it is my responsibility to know if my insurance has any Deductible, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my Insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

Signature: ____ **Date:** __________________
(please sign here – Patient or Responsible Party)

Responsible Party Name: ______________________________________
(please print name of Responsibility Party if different from Patient)

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

____
Name of Patient (Print)

____
Signature of Patient   Date of Signature

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

Request for Confidential Communication of Your Protected Health Information

Please circle your response to the following:

May we leave messages concerning your **appointments** with a co-worker, receptionist or secretary that regularly answer your calls? Yes No N/A

May we leave **messages** on a voice mail at work? Yes No N/A

May we discuss your **appointments/treatment** with your spouse? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your **appointments/treatment** with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may we discuss your **appointments and/or treatment** with your children? Yes No N/A

You must inform us **in writing** if you wish to change the manner in which this office communicates to you.

Thank you.

Please place in the patient's medical record.

12/06

Patient Name: ____ **Date of Birth:** ___________

First Name M.I. Last Name

MEDICAL PHOTOGRAPHY CONSENT

I consent to medical images and / or video being made of me or my child / dependant. I agree that duplicates may be made for the referring doctor.

I agree that the images and results of my investigative tests may be:
(please tick below to show consent)

	Yes	No
…placed in my medical record for future treatment		
…electronically emailed to my treating health professional		
…used by health professionals for education and training		
…used in paper or electronic health publications		

PATIENT SIGNATURE: ________________________________ **DATE:** _______________

____ **DATE:** _______________
Signature of Parent or other Legally Responsible Person

TREATMENT OBSERVATION CONSENT

Verity Radiation Therapy is an official Varian Reference Site. Periodically, we host visitors from other centers who wish to learn about our equipment. These are Radiation Oncology clinical personnel and administrators, and Varian representatives. A Verity Radiation Therapy staff member will ask your approval each time there is an outside observer present during your treatment. All patient information will be kept strictly confidential.

I ☐ DO ☐ DO NOT consent to periodic observers during my treatment
(Check one)

PATIENT SIGNATURE: ________________________________ **DATE:** _______________

____ **DATE:** _______________
Signature of Parent or other Legally Responsible Person

Medical Release of Information Form

Patient Name:________________________________ Date of Birth:_____________________

Social Security #:_______________________________Previous Name:____________________

I request and authorize____
(Name of Physician and Clinic/Practice)

To release the medical record of the above named patient to:

Name of recipient:____

Address:____

City & State:____ Zip Code:__________________

Reason for release:____

This request and authorization applies to: (initial appropriate line)

____Health Care information relating to the following treatment condition or dates of treatment:
____
This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

____All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____ I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

____
Signature of patient or authorized representative Date

____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information I can contact *Cherrie Crawley at 972-739-3070*.

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of [name of practice]. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies who support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information they review is not removed from the premises of this practice. Provider may also disclose the medical information of decedents for a research project, so long as the information is necessary for the research.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you would like this office to communicate your health information to you in a confidential manner, please indicate your wishes on the '*Acknowledgement of Receipt of HIPAA Notice of Privacy Practices'* form.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information;
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; &
- The right to receive a printed copy of this notice.

Practice Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter or placing a call outlining your concerns to:

HIPAA Privacy Officer
MedicalEdge Healthcare Group, Inc.
9229 LBJ Freeway
Dallas, TX 75243
(972) 792-3803

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit complaints to the Secretary of Health and Human Services.

You will not be penalized or otherwise retaliated against for filing a complaint.