PERMIAN PREMIER
HEALTH SERVICES

In order for us to expedite the registration process, please be sure to arrive at least 15-30 minutes early. In addition, please bring the following with you to your scheduled appointment:

1) New patient packet
2) All applicable insurance cards
3) Driver's License or some other form of photo identification
4) A form of payment if you have a co-pay or deductible due For your convenience we take:
    a. Cash
    b. Check
    c. Debit cards
    d. Visa, MasterCard, American Express and Discover
5) List of medications you are currently taking
6) Any lab results or x-rays that are pertinent to your visit
7) Any medical records from referring physicians

We look forward to seeing you. If you must cancel or reschedule, please give the office at least a 24 hour notice.

Permian Premier Health Services, Inc.

Clinic name: _____

Physician/Provider Being seen today: _____

PATIENT INFORMATION (Patient Being Seen today)

Date	Patient Name (Legal Name): Last	First (Legal Name)	Middle (Legal Name)	
Address (Permanent Residence)		City	State	Zip
Address (Temporary Address)		City	State	Zip
Gender	Date of Birth	Status: [ ] Married [ ] Widowed [ ] Single [ ] Divorced [ ] Separated	Home Phone	
Social Sec.#	Occupation	Employed By	Business Phone	
Employer Address	City		State	Zip
Driver License #	E-mail Address		Cell Phone #	

RESPONSIBLE PARTY INFORMATION (If patient is under 18 person responsible must be present)

Relationship To Patient	Name Last (Legal Name)	First (Legal Name)	Home Phone	
Home Address		City	State	Zip
Social Sec.#	**Occupation**	**Employed By**	Business Phone	
Company Address		City	State	Zip
Spouse First Name (and last if different)		Employer	Phone	

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES) DO YOU HAVE INSURANCE? YES ☐ No ☐

Insurance Company	Copay Amount	Policy holder	Policyholder Date of Birth / /	Patient Relationship to Insured: Self	Spouse	Child	Other
Insurance Company Address				Phone			
Social Sec.#		Policy /ID #	Medicare #	Medicaid #			
2nd Insurance Company	Copay Amount	Policy holder	Policy holder Date of Birth / /	Patient Relationship to Insured: Self	Spouse	Child	Other
Social Sec.#	Policy /ID #	Insurance Company Address		Phone			

INJURY INFORMATION (Must be filled out completely)

What type of injury are we seeing you for? (indicate right or left if appropriate)		
Is this employment related? Yes [ ] No [ ] If so, Who is your company's industrial carrier?		
Accident or Injury (Please circle one)	**Date of accident or Injury**	**Place of Accident: [ ] Work [ ] Auto [ ] Home [ ] School [ ] Other**
Name of School	Sport	**How was injury sustained?**
NAME AND ADDRESS OF PLACE OF INJURY:		

EMERGENCY CONTACT / REFERRING PHYSICIAN INFORMATION:

EMERGENCY CONTACT (FULL NAME /RELATION TO PATIENT):	**Phone (REQUIRED)**
REFERRING PHYSICIAN (NAME & ADDRESS):	**Phone (REQUIRED)**

RACE	ETHNICITY
❑Asian ❑Black or African ❑Caucasian ❑Hispanic ❑Middle Eastern ❑Other ❑Unknown / Not Reported	❑HISPANIC OR LATINO ❑UNKNOWN/ NOT REPORTED ❑NON HISPANIC OR LATINO

REFERRAL SOURCE (How did you hear about us?)

❑Billboard/Signage ❑Direct Mail ❑Family/Friend ❑Hospital ❑ Insurance Plan ❑ Internet/Web ❑Newspaper/Magazine ❑ Radio ❑Seminar ❑TV ❑ Yellow Pages

CONSENT TO TREATMENT

1. **I hereby voluntarily consent to outpatient care at Permian Premier Health Services clinics, encompassing routine diagnostic procedures, examinations and medical treatment including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of X-rays, heart tracings and administration of medications prescribed by the physicians.**

2. **I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Permian Premier Health Services clinics, and its physicians and physician assistants as is necessary in the medical staff's judgment.**

3. **I understand that this consent form will be valid and remain in effect as long as I (he/she) attend any Permian Premier Health Services clinic.**

4. **I hereby authorize my insurance carrier(s) to pay Permian Premier Health Services clinics, all benefits due me, if any, by reason of service described in the statements rendered and as provided for in the policy contract with my insurance carrier(s).**

5. **This form has been explained to me and I understand its contents.**

_____ _____

Signature of Patient or Person Authorized to Consent for Patient **Date**

If patient is a minor or is unable to consent, _____

Patient Name

A. Patient is a Minor _____ years of age.

Name of Father _____ Name of Mother _____

B. Patient is unable to consent because _____

_____ _____

Signature of Person Authorized to Consent for Patient **Relationship**

****REQUIRED** RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company is responsible for payment of this account

Signature Of Patient (or Responsible Party): _____ Date Signed_____

Printed Name_____

PERSONAL PAY PATIENTS
As a courtesy to our personal pay patients we extend a 35% discount for payments received at the time of services at our facility.
*******NOTE ****NOT APPLICABLE FOR THE FOLLOWING:***

- ***SURGICAL WT. LOSS SURGERY***
- ***FAA EXAMINATIONS***
- ***PLATELET RICH PLASMA INJECTIONS***

PAYMENT ARRANGEMENTS
Services are payable upon date performed or upon receipt of monthly statement. If extended terms are required on balances, Office Manager of our clinics will need to be contacted to establish a payment schedule. For your convenience we accept VISA, MASTER CARD, American Express and DISCOVER CARD.

Notifications
I hereby authorize for Permian Premier Health Services (PPHS) to notify me of upcoming appointments via various methods of communication such as reminder notes, phone calls, text messaging or email. To Opt in to receive text messaging notifications, please text the following word **TXMD** to 622622. You may Opt out from the text messaging notifications by sending a text with the word **STOP** to 622622.

FINANCE CHARGE
The finance charge is an annual percentage rate of 18% applied to the 90 day balance after deducting payments and credits.

ATTORNEY/ COLLECTION FEE'S

In the event it becomes necessary to refer the account to an ATTORNEY, or OUTSIDE COLLECTION AGENCY, you hereby agree to pay all attorney fees, court costs, and a 25% COLLECTION FEE.

YOUR BILLING RIGHTS (A copy of this notice may be provided upon request)
This notice contains important information about your rights and our responsibility under the Fair Credit Billing Act.

Patient is responsible to notify us in case of Errors or Questions regarding your bill:
If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write or phone us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. **You can telephone us, however you must speak with a member of the business office, leaving a message will not preserve your rights.**
In your letter, the following information must be provided:

- Your Name and account number
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error.

Your Rights and our Responsibilities After We Receive Your Written Notice:
We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 60 days we must correct the error or explain why we believe the bill was correct.
After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount NOT in question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a billing error on your account, you will not have to pay any finance charges related to any questioned amount. IF WE FIND YOUR ACCOUNT CHARGES TO BE CORRECT, YOU MAY HAVE TO PAY FINANCE CHARGES, AND YOU WILL HAVE TO MAKE UP ANY MISSED PAYMENTS ON THE QUESTIONED AMOUNT. In either case, we will send you a statement of the amount you owe and the date that it is due.
IF AT THAT TIME, YOU DO NOT PAY THE BALANCE OF YOUR ACCOUNT, WE MAY REPORT YOU AS DELINQUENT.

MANAGED CARE/COMMERCIAL INSURANCE
PATIENT'S ARE RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR NON COVERED SERVICES AS DICTATED BY THEIR MANGED CARE PLAN. **IT IS THE PATIENTS RESPONSIBILITY BEFORE MAKING AN APPOINTMENT, TO CONFIRM WITH THEIR INSURANCE COMPANY WHETHER THE PHYSICIAN IS COVERED AS AN IN-NETWORK PROVIDER FOR THEIR PLAN. THE PATIENT IS RESPONSIBLE FOR SERVICES RENDERED BY PERMIAN PERMIER HEALTH SERVICES, INC. PHYSICIAN'S THAT ARE NOT PROVIDERS OR IN-NETWORK PROVIDERS FOR THEIR PLAN.**
If an overpayment occurs, Permian Premier Health Services, Inc. will refund the patient or the insurance company, whoever is due, within a reasonable length of time.

I declare that the above answers and statements are true and correct to the best of my knowledge and belief. I hereby acknowledge that I have read this entire document, and agree to all of the terms herein.

Date:	**X_____ Signature**
Date:	**X_____ Signature of responsible party/Patient**

NOTICE OF PRIVACY PRACTICES

We are required to provide you with our "Notice of Privacy Practices." Please review this information. Return the completed coversheet to the receptionist. You may keep the attached Notice or return it along with the coversheet.

Please provide the information below.

Your Name (Patient) please print

_____

Date of Birth _____

I have been provided with a copy of the "Notice of Privacy Practices."

Your signature (Patient or Personal Representative)

If a personal representative description of personal representative's authority:

_____ Date _____

May we leave medical information on your "home" answering machine? _____Yes _____ No
May we leave appointment information on your "home" answering machine? _____ Yes _____ No

Please list below the names, relationship, and phone number of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

	Name	Relationship	Phone Number
1.			
2.			
3.			

_____
Signature of Patient/Parent/Legal Guardian Date

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself please sign below.

_____
Signature of Patient/Parent/Legal Guardian

THE ABOVE INFORMATION IS PRIVATE AND CONFIDENTIAL AND WILL BE PLACED IN YOUR CHART.

PERMIAN PREMIER HEALTH SERVICES, INC

HIPPA Effective Date: April 14, 2003

Joint Notice of Privacy Practices

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.

1. **Purpose:** Permian Premier Health Services and its professional staff, employees, and volunteers and all of its affiliated entities (referred to collectively as Clinic) follow the privacy practices described in this Notice. The Clinic maintains your medical information in records that will be maintained in a confidential manner, as required by law. However, the Clinic must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, the Clinic must share your medical information as necessary for treatment, payment and health care operations.

2. **Organized Health Care Arrangement.** The Clinic and its medical staff participate together in an organized health care arrangement to provide health care to you at the Clinic. This Notice applies to physicians and other members of the Medical Staff who have agreed to abide by its terms concerning the services they perform at the Clinic or at a Clinic department. This Notice does not create an agency relationship, a joint venture, or any other legal relationship between those covered by this Notice. Under this arrangement, the Clinic may share your medical information as necessary for treatment, payment and health care operations.

3. **What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your physician may share information about your condition with the pharmacist to discuss appropriate medications or with radiologists or other consultants in order to make a diagnosis. The Clinic may use your medical information as required by your insurer or HMO to obtain payment for your treatment and Clinic stay. We also may use and disclose your medical information to improve the quality of care, *e.g.*, for review and training purposes.

4. **How Will the Clinic Use My Medical Information?** Your medical information may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

    - Clinic Directory, which may include your name, general condition, and your location in the Clinic.
    - Religious affiliation to a Clinic chaplain or member of the clergy.
    - Family members or close friends involved in your care or payment for your treatment.
    - Disaster relief agency if you are involved in a disaster relief effort.
    - Appointment reminders.

- To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
- Fundraising activities by the Clinic's Foundation, but such information will be limited to your name, address, phone number, and the dates you received services at the Clinic. (You will have an opportunity to refuse to receive these communications.)
- As required by law.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
- Health oversight activities, *e.g.*, audits, inspections, investigations, and licensure.
- Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
- Law enforcement (*e.g.*, in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the Clinic's premises; and in emergency circumstances relating to reporting information about a crime.)
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Inmates. (Medical information about inmates of correctional institutions may be released to the institution.)
- Workers' Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- To carry out health care treatment, payment, and operations functions through business associates, *e.g.*, to install a new computer system.

5. **Your Authorization Is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information unless you authorize (permit) the Clinic in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

6. **You Have Rights Regarding Your Medical Information.** You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by the Clinic:

- **Right to request restriction.** You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (*e.g.*, you may ask us not to disclose that you have had a particular surgery), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- **Right to inspect and copy.** You have the right to inspect and copy your medical information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by the Clinic. The Clinic will comply with the outcome of the review.
- **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment on the form provided by the Clinic, which requires certain specific information. The Clinic is not required to accept the amendment.
- **Right to accounting of disclosures.** You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment payment or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there may be a charge.
- **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy.

7. **Requirements Regarding This Notice.** The Clinic is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. The Clinic may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future. Each time you register at the Clinic for health care services as a patient, you may receive a copy of the Notice in effect at the time.

We may contact you by telephone or mail to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government for us. The contact information for the United States Department of Health and Human Services is:

U.S. Department Of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

You are required by law and regulations to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Permian Premier Health Services
615-467-1264

This notice is effective on the following date: March 01, 2010

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.