Patient Registration Information

Please print and complete all sections below

Patient's Personal Information: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Race: American Indian-Alaska Native-Asian-Black/African American-Native Hawaiian-White-Pacific Islander-More than one race-Refuse to report
Ethnicity: Hispanic or Latino---Not Hispanic or Latino---Refuse to report/unreported
Preferred Language: English---Spanish---Other

Name: _____

Last Name First Name M. Initial

Date of Birth _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

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

Driver's License # _____ State issued: _____ Email Address: _____

Guarantor of Account Relationship to Patient: ☐ Self ☐ Spouse ☐Child ☐ Parent ☐ Other _____

Name: _____Date of Birth _____/_____/_____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Employment Information: ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Employer: _____ Occupation: _____

Work Phone: (_____)_____ Address: _____

Insurance Information: Please present insurance cards to receptionist.

Primary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Secondary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

How were you referred to Harmony Clinics? Television_____ Social Media/Facebook/Twitter_____

Family/Friend_____ Word of Mouth_____ Walk-In_____ Other, Please Explain_____

Emergency Contact:

Name: _____ Relationship: _____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Harmony Clinics, and any assisting physicians for services needed. I understand that I am financially responsible for all charges whether of not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature Date

HIPAA AUTHORIZATION

I, _____, give permission to Harmony Integrative Medicine Clinics, PLLC to:

☐ Use the following protected health information, and/ or

☐ Disclose the following protected health information to:

Names of entity or person to receive information:

_____

_____

_____

Information to be disclosed (check all that apply):

☐ Medical Records

☐ Treatment Records

☐ Diagnostic Records

☐ Other _____

This protected health information is being used or disclosed for the following purposes:

_____

_____

_____

This authorization expires on _____/_____/_____ or in 2 years if not specified otherwise.

If the person or entity receiving this information is not a health care provider or a health plan covered by federal privacy regulation, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment of your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending a written notification to Harmony Integrative Medicine Clinics, PLLC at 4412 Kell Blvd., Wichita Falls, Texas 76309. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorizaton.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

FINANCIAL POLICY

Thank you for choosing Harmony Clinics for your healthcare needs. This policy was created to outline our expectations of you regarding your financial responsibilities to this clinic.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

As a patient of Harmony Clinics you will be required to sign a financial responsibility form. Payment is required at the time services are rendered unless other arrangements have been made in advance. Patients with an outstanding balance must make arrangements prior to scheduling appointments. **Any two consecutive months without payment or contact with the billing department will cause the remaining balance to be turned over to collections. Accounts that have been turned to an outside collection agency MUST be paid in full prior to scheduling appointments, (including any labs), and/or being seen in our walk-in clinic.**

INSURANCE

We bill participating insurance *companies* as a courtesy service to you. You are expected to pay your ***deductible and co-payments or coinsurance*** at the time of service. On occasion, your insurance may determine that the services you received are not covered. ***Please read your insurance handbook and be aware of services that are considered non-covered***. When in doubt, contact your insurance company directly for clarification. You will be responsible for services not covered by your insurance plan. If we do not receive payment from your insurance company within 90 days of the claim filing date, patients will be expected to pay the balance in full.

SELF-PAY PATIENTS

Self-Pay patients and patients who present without proof of insurance for verification are required to pay for services in full at the time services are rendered. Also, a $75.00 deposit is required at the time of check-in. We understand that affordable insurance coverage is not readily available for all of our patients. We also realize the lack of insurance coverage may determine the level of care that individuals seek for themselves or their families. Bearing that in mind, our Self-Pay policy includes discounted rates for our services. If circumstances make it impossible to pay in full at the time of service, we require a minimum payment of $75.00. Any charges not paid on the date services are rendered will NOT receive the Self-Pay discount. **PLEASE NOTE YOUR BALANCE TODAY IS AN <u>ESTIMATE</u> OF YOUR CHARGES. YOU MAY STILL RECEIVE A BILL FOR SERVICES RENDERED.**

FORMS OF PAYMENT

We accept Cash, Checks, Visa, MasterCard and Discover.

RETURNED CHECKS

All returned checks are handled through Check Net. Any returned check must be taken care of prior to scheduling an appointment. In the event of a second returned check, this method of payment will no longer be accepted.

I have read and understand the Harmony Clinics' Financial Policy.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Notification Regarding Radiology and Laboratory Services

Please be advised that if you receive any technical services such as x-rays and pathology, you will be billed the professional services by other providers as well. For example, your pathologist and radiologist **(those who interpret lab and x-rays)** bill separately from our clinic and may not participate in the same health plans as Harmony Clinics. You will be responsible for paying these providers subject to the terms of your health plan or insurance, if any. Additionally, Clinical Pathology Laboratories, INC. which is an outside laboratory will bill for all lab services. If you have questions regarding these bills please call the billing number located on the statement you received.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Consent to Text or Email for Reminders and Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind them of an appointment, to obtain feedback of their experience with our healthcare team, and to provide general health reminders/information. By signing below, you consent to receiving appointment reminders and other healthcare communications/information at the email or text address listed.

_____(patient initials) I consent to receive text messages from the practice on my cell phone, as well as any number forwarded or transferred to that number, or emails that include communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number I authorize to receive text messages is: _____
The e-mail address I authorize to receive emails messages is: _____

The practice does not charge for this service, but standard text messaging rates may apply according to your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via e-mail and/or text.

_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via e-mail.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Pediatric Medical History

Name:_____ DOB:____/____/_____ Date:____/____/_____

Pediatric Questionnaire

Infants & Children through age 15

_____ ☐ Male ☐Female
Patient's Name

_____ _____
Form completed by Date

_____ _____
Patient's birth date Patient's current age

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	List any health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____
_____

If the child's mother and father do not live together or if child does not live parents, what is the child's custody status?
_____
_____

If one or both parents are not living in the home, how often does the child see the parent(s)? _____

Birth History

Birth weight? _____ lbs. _____ oz.

Was the baby born ☐ at term? ☐ early? ☐ late?

If early, how many weeks' gestation? _____

Did mother have any illness or problems with pregnancy?
_____

During pregnancy, did mother

☐smoke? ☐drink alcohol? ☐use drugs or medications
What: _____ When: _____

Was the delivery ☐ vaginal? or ☐ Cesarean?

If Cesarean, why? _____

Did the child have problems right after birth? ☐Yes ☐No

If yes, explain: _____

Was initial feeding ☐breast milk? or ☐formula?

Did the baby go home with mother from hospital?
☐ Yes ☐ No Explain: _____

General

Do you consider your child to be in good health? ☐Yes ☐ No Explain _____

Does your child have any serious illness or medical conditions? ☐Yes ☐ No Explain _____

Has your child had any serious injuries or accidents? ☐Yes ☐ No Explain _____

Has your child had any surgery? ☐Yes ☐ No Explain _____

Has your child ever been hospitalized? ☐Yes ☐ No Explain _____

Is your child allergic to any medications or drugs? ☐Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional development? ☐Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐Yes ☐ No Explain _____

If your child is in school, please answer the following questions:

How is child's behavior at school? _____

Has the child failed or repeated a grade in school? _____

How does the child perform in academic subjects? _____

Is the child in special or resource classes? _____

Office Use Only

Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____

Name:_____ DOB:____/____/_____ Date:____/____/_____

Past History

Has your child have or does your child currently have? Patient's Name:_____

Chickenpox	☐ No	☐ Yes	When: _____
Frequent ear infections	☐ No	☐ Yes	When: _____
Problems with ears or hearing	☐ No	☐ Yes	When: _____
Nasal allergies	☐ No	☐ Yes	When: _____
Problems with eyes or vision	☐ No	☐ Yes	When: _____
Asthma, bronchitis, pneumonia	☐ No	☐ Yes	When: _____
Heart problem or heart murmur	☐ No	☐ Yes	When: _____
Anemia or bleeding problem	☐ No	☐ Yes	When: _____
Blood transfusion	☐ No	☐ Yes	When: _____
Frequent abdominal pain	☐ No	☐ Yes	When: _____
Constipation requiring doctor visits	☐ No	☐ Yes	When: _____
Bladder or kidney infection	☐ No	☐ Yes	When: _____
Bed-wetting (after age 5)	☐ No	☐ Yes	When: _____
Chronic or recurrent skin problems	☐ No	☐ Yes	When: _____
Frequent headaches	☐ No	☐ Yes	When: _____
Convulsions or other neurological problem	☐ No	☐ Yes	When: _____
Thyroid or other endocrine problem	☐ No	☐ Yes	When: _____
Diabetes	☐ No	☐ Yes	When: _____
Alcohol and/or dug abuse	☐ No	☐ Yes	When: _____
Girls—Have menstrual periods started?	☐ No	☐ Yes	When: _____
Girls—Are there problems w/ periods?	☐ No	☐ Yes	When: _____

Family History

Have any family members had the following:

Deafness	☐ No	☐ Yes	Who _____ Comment _____
Nasal allergies	☐ No	☐ Yes	Who _____ Comment _____
Asthma	☐ No	☐ Yes	Who _____ Comment _____
Tuberculosis	☐ No	☐ Yes	Who _____ Comment _____
Heart disease (before age 50)	☐ No	☐ Yes	Who _____ Comment _____
High blood pressures (before age 50)	☐ No	☐ Yes	Who _____ Comment _____
High cholesterol	☐ No	☐ Yes	Who _____ Comment _____
Anemia	☐ No	☐ Yes	Who _____ Comment _____
Bleeding disorder	☐ No	☐ Yes	Who _____ Comment _____
Liver disease	☐ No	☐ Yes	Who _____ Comment _____
Kidney disease	☐ No	☐ Yes	Who _____ Comment _____
Diabetes (before age 50)	☐ No	☐ Yes	Who _____ Comment _____
Bed-wetting (after age of 10)	☐ No	☐ Yes	Who _____ Comment _____
Epilepsy or convulsions	☐ No	☐ Yes	Who _____ Comment _____
Alcohol and/or drug abuse	☐ No	☐ Yes	Who _____ Comment _____
Mental illness	☐ No	☐ Yes	Who _____ Comment _____
Mental retardation	☐ No	☐ Yes	Who _____ Comment _____
Immune problems, HIV, or AIDS	☐ No	☐ Yes	Who _____ Comment _____

Additional family history _____

_____

Office Use Only

Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____

Harmony Clinics