Patient Registration Information

Name: (Last, First, Middle) _____, _____, _____
Date of Birth: ____/_____/_____ SSN#_____-_____-_____ Sex: M / F
Contact Info: Primary #: (____) _____-_____ Secondary #: (____) _____-_____
Email: _____@_____
Address: _____City_____St.____Zip_____
Preferred Language: _____ Race: _____
Name of Employer: _____ Job Title: _____

Emergency Contact:
Name: _____ Relation: _____
Phone #: _____
Address: _____ City _____ St.____ Zip_____

Insurance Information:

Plan Name: Primary _____ Secondary _____

Member ID #: Primary _____ Secondary _____

Group # _____ Secondary _____

Health History:

Childhood Illness:
__ Measles __ Mumps __ Rubella __ Chickenpox __ Rheumatic Fever __
Polio __ Other: _____

Immunization/Vaccination:
__ Tetanus (___/___/_____)
__ Hepatitis (___/___/_____)
__ Influenza (___/___/_____)
__ Pneumonia (___/___/_____)
__ Chickenpox (___/___/_____)
__ MMR (Measles, Mumps, Rubella) (___/___/_____)

Surgical History:

Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____
Procedure: _____ Year: _____ Location: _____

Are you currently or ever been diagnosed with any of the following?

__ Amputation(s)
__ Anemia
__ Anxiety
__ Arthritis
__ Autoimmune Disease
__ Back / Neck Pain
__ Bladder Incontinence
__ Bowel Disease
__ CAD
__ Cancer(s)
__ Cataracts
__ Colitis or Diverticulosis
__ Congestive Heart Failure
__ COPD or Emphysema
__ Dementia or Memory Loss
__ Depression and/or Anxiety
__ Diabetes (Type 1 / Type 2)
__ Endocrine Disease
__ Eye Problems
__ Gastritis / Ulcer
__ GERD / Acid Reflux
__ Gout
__ Headaches / Migraines
__ Hearing Loss / Ear Problems
__ Heart Disease
__ Heart Rhythm Disorder
__ Hemorrhoids
__ HBP (High Blood Pressure)
__ High Cholesterol
__ Kidney Disease
__ Liver Disease
__ Lung Disease
__ Mental Illness
__ Movement Disorder
__ Nerve Disease
__ Osteopenia / Osteoporosis
__ Overweight / Obesity
__ Pneumonia
__ Prostate Cancer
__ Seizures
__ Stomach / Duodenal Ulcer
__ Stroke / TIA
__ Thyroid Disease
__ Tuberculosis
__ Urinary Problem(s)
__ Viral Disease

__ Other: _____

Health Habits:

Tobacco Use: (Y / N) Currently: (Y / N) Previously: How long? _____
__Cigarettes: ____/Day __Chew: ____/Day __Cigars: ____Day

_____

_____ *Caffeine:* ___ None ___ Occasional __Moderate ___Regularly: _____/Day

_____

_____ *Drugs:* Do you currently use recreational or illicit drugs? (Y / N)

_____

_____ *Alcohol:* (Y / N) _____/Week

_____

_____ *Exercise:* __ Not at all __ Mild __ Occasional __ Regularly

_____

_____

Diet: (Y / N) Prescribed by physician? (Y / N)Number or Meals: _____/Day

Salt Intake: __ High __Med __Low Fat Intake: __ High __Med __ Low

_____

WOMEN ONLY:

Last PAP Smear Date: _____

Last Mammogram Date: _____

Last Menstrual Period: _____ OR Menopause Start Date: _____

Currently Pregnant: (Y / N) Breastfeeding: (Y / N) Possibility of being pregnant? (Y / N)

Have you had the following: __ D&C (Y / N) __ Hysterectomy (Y / N) __Cesarean (Y / N)

Any urinary tract, bladder, or kidney infection(s) with in the last year? (Y / N)

Blood in urine? (Y / N)

Problems controlling urine? (Y / N)

Hot flashes or sweating at night? (Y / N)

_____

MEN ONLY:

Do you get up in the middle of night to urinate? (Y / N)_____/Per night

Feel a burning while urinating? (Y / N)

Blood in urine? (Y / N)

Do you feel discharge from penis? (Y / N)

Has the force of urine decreased? (Y / N)

Any bladder, kidney or prostate infection(s) within the last year? (Y / N)

Problems emptying bladder completely? (Y / N)

Testicular pain or swelling? (Y / N)

Difficulty with erection or ejaculation? (Y / N)

Last Prostate Exam Date: _____

Family Health History:

Family Member: _____ Diagnosis: _____ Age of DX: _____
Family Member: _____ Diagnosis: _____ Age of DX: _____
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Family Member: _____ Diagnosis: _____ Age of DX: _____

Financial Policy:

We are happy that you have selected After Hours Health and Wellness Clinic for your healthcare needs and look forward to working with you. To better help you understand your financial responsibilities as a patient in relations to your medical care, we would like to outline such financial policies.

Patients are expected to provide identification and if insure, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for such services at the time of services. This includes any past due balance from prior dates of service. Returned checks will be subject to fees.

Medicare Patients: The office will bill the Medicare intermediary. Patients are responsible for following: Annual Medicare deductible, all applicable co-pays of allowed charge, any non-covered services, any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed and "Advanced Beneficiary Notice" (ABN).

Medicare Supplemental and Secondary Insurances: The practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payments of the co-pay, coinsurance and/or deductible, or non-covered amounts at the time of services as well as for any changes for which the patients failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the practice. Patients are responsible for the balance in full if not paid by the insurance in 30 days. If the patient is not finically prepared to pay co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to be seen by physician or nurse practitioner. If a patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Out of State Insurance: If patient presents with an out of state HMO/PPO insurance card(s), we will need to verify the patients benefits for out-of-state or out-of-network benefits.

The patient may be required to make payment in full or pay any co-pay, co0insurance or deductible.

Assignment and release: I hereby assign my insurance or other third-party carrier benefits to be paid directly to the medical provider practice, realizing I am responsible for any resulting balance. I also authorize the medical provider to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that o a, financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

Electronic check Conversion: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account to process the payment as a check transaction. When we use information form your check to make an electronic fund transfer, funds may be withdrawn from account the same day.

Patient Signature: _____

Printed Name: _____

Date: _____

Medicines

Name:	Direction:	Days:	Qty:

Allergies:

Name:	Reaction:

Pharmacy:

Name:	Address:

Patient Sign: _____ Staff Sign: _____

HIPAA Compliance Patient Consent Form:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing consent. The terms of notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. HIPAA (Health Insurance Portability Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not agree to those restrictions.
- The patient has the right to revoke this consent in wiring at any time and full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or send a text to you to confirm appointments? __ YES __NO
May we leave a message on your answering machine at home or on your cell? __YES __NO
May we discuss your medical condition with members of you family? __YES __NO
If YES, please name such family member allowed:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

This consent was signed by: _____
(PRINT NAME)

Signature: _____ Date: _____
Witness: _____ Date: _____

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my personal medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release is as follows:

Complete Records	History & Physical	Progress Notes
Care Plan	Lab Reports	Radiology Reports
Pathology Reports	Treatment Record	Operative Reports
Hospital Reports	Medication Record	Other (please specify below)

_____

Release my protected health information to the following physician/person/facility/entity and/ or those directly associated with my medical care:

Name: After Hours Health and Wellness Clinic
Address: 1603 Babcock Rd Ste 234
City, State, Zip Code: San Antonio, Texas 78229
Email: info@afterhourshealthandwellnessclinic.com
Phone: 210-998-1810
Fax: 210-998-1820

Patient Signature: _____

Patient Printed Name: _____

Date: _____

No Call No Show Policy

We schedule our appointments to ensure each patient receives the ample allotted amount of time to be seen by our medical provider and medical staff. It is very important to honor your scheduled appointment time with us and arrive promptly.

If your schedule changes and you are unable to keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to receive their needed medical care, please give us at least 24-hour notice.

If you do not cancel or reschedule your appointment with at least 24-hour notice, we may assess a **$25.00 fee** to your account. This "no-show fee" will not be reimbursable by your insurance company. You will be billed directly and held responsible for such a balance.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

After Hours Health and Wellness Clinic

I understand the "no-show" policy of After Hours Health and Wellness Clinic and agree to provide a credit card number, which may be charged $25.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge to the payment method provided.

Patient Signature: _____

Patient Name: _____

Date: _____