Rachel B. Head, MD
Urology

Rachel B. Head, MD
617 Russell Blvd
Nacogdoches, TX 75965
www.headurology.com

PATIENT INFORMATION: Today's Date: _____

Name: _____ SSN: _____

Address: _____ City/State/Zip: _____

Primary Phone (where you can be reached): _____ Other Phone: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Employer: _____ Work Phone: _____

Email: _____ Spouse's Name: _____

Race: _____ Hispanic _____ African American _____Caucasian _____ Asian _____ Other

Who referred you? _____Physician _____Family _____Friend _____Phone Book _____Other

Primary Physician _____ Referring Physician _____

Reason for Visit: _____

Pharmacy: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Patient's Name: _____

Relationship to Insured: _____Self _____Spouse _____Child _____Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ Insured's Name: _____

Secondary Insurance: _____ Patient's Name: _____

Relationship to Insured: _____Self _____Spouse _____Child _____Other

Policy #: _____ Group#: _____

Employer: _____ SSN: _____ Insured's Name: _____

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:
If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.
Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also be your responsibility. Your office co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

RACHEL B. HEAD, MD
OFFICE FINANCIAL POLICY

Dr. Head is committed to maintaining a healthy patient-physician relationship and providing you with the best urology care possible. Our goals are best achieved when communication of our office procedures are given to you upon arrival. We strive to give you an excellent medical experience while in our office. We ask that you honor our policies so that you may have the same special treatment as each and every patient.

Please initial each statement after reading:

INSURANCE

As a courtesy to our patients, all services performed in our office and at the hospital will be submitted to your insurance company. It is the responsibility of the patient to provide accurate insurance information. If the insurance information you provide is incorrect or expired, and you provide no current insurance information, the balance becomes your responsibility. _____ (initial) According to your insurance plan, you are responsible for co-payments and deductibles. We are under contract with your insurance company to collect all co-pay amounts at the time of service. Your co-pay is to be collected before you are seen in the office. If you are unable to pay your co-pay at this time, you will be asked to reschedule. If your insurance plan requires you to pay a percentage of your doctor's visit or surgery (example 80%/20%), you will be asked to pay this amount at the time of service. If you are in need of surgery, we will collect the estimated amount that your insurance does not cover up front. If you have any questions regarding this or are in need of payment arrangements, you may speak to the office manager. It is important for you to read and understand your insurance policy. Any services performed by Dr. Head that are not covered by your insurance, will be your responsibility. Dr. Head reserves the right to refuse your insurance plan if she is not in network. _____ (initial)

NO INSURANCE

If you have no insurance, you will be asked to **pay** your visit **up front**. If you are in need of surgery and cannot pay the full amount up front, you may speak to the office manager for payment arrangements. _____ (initial)

REFERRALS

If your insurance requires a referral from a primary care physician, **you will be required to see your primary care doctor to get the referral before you come for an appointment at our office**. If you fail to comply with your insurance and our office policy you may be responsible for payment for all services or for paying a deductible and coinsurance. It is your responsibility to obtain a referral or prior authorization if your medical coverage requires it. _____ (initial)

BILLING AND PAYMENTS

The patient/patients guardian is responsible for co-pays and uninsured amounts at the time of the service. We accept payments via Check, Cash, Money Order, Mastercard, Visa, Discover, American Express and Care Credit. If any patient was to have a potential credit on account, it can be used for future dates of service. _____ (initial)

Statements will be mailed monthly and payment is due upon receipt, if payment is not received within 120 days it will be turned over to a collection agency. _____
(initial)

APPOINTMENTS

Please make every effort to arrive on time for your scheduled appointment. If you cannot make it to your appointment, please call as quickly as possible to reschedule/cancel. If you arrive more than 15 minutes late you will be asked to reschedule to the next available date. Missed appointments represent a cost to us, and to the patients that need care. There is a **$25.00 charge for missed appointments without at least a 3-hour cancellation prior to scheduled appointment time. There will be a $50.00 Charge for missed or late procedural appointments. There will be a $100 charge for surgeries cancelled within 24 hours of the scheduled surgery.** _____ (initial).

MEDICAL RECORDS AND FORMS

For your protection, medical records will not be released to individuals that are not listed in your chart. **Medical Records requested by an attorney, a medical source or patient may have a $25.00 charge.** For any other forms there is a charge of $10.00 per page. Turnaround time for forms could take up to 5-7 days. _____ (initial)

PRESCRIPTION REFILLS

Please notify our office **24 hours in advance for any prescription refills**. If you see that you are going to run out of your prescription over the weekend, please call our office by Thursday so we can get it called in by noon on Friday. **We reserve the right to limit or deny refills as needed to protect your health**. Dr. Head reserves the right to charge $25.00 for repeated narcotic prescription refills if necessary. _____ (initial)

TELEPHONE CALLS

Dr. Head, as well as staff **does not** return calls while seeing patients. Your call will be returned either at lunch or after seeing patients for the day. If your call is due to a medical emergency, you should dial 911 or go to the emergency room at Nacogdoches Memorial Hospital or Nacogdoches Medical Center. Dr. Head will be notified by the emergency room upon your arrival. _____ (initial)

RELEASE AND IMPORTANT NUMBERS

We require that you provide us with a copy of your driver's license, insurance card and social security number. These documents are necessary for filing insurance and collection efforts. We cannot see you without this information.
_____ (initial)

RETURNED CHECKS

A $25.00 fee will be charged for all returned checks. _____ (initial)

RACHEL B. HEAD, MD
AUTHORIZATIONS

PAYMENT OF SERVICES

I understand that **I am responsible for payment of all medical services rendered to me and/or my dependents**, regardless of the decision of reimbursement made by my insurance carrier. I further understand that **I am also responsible for any non-covered services. It is my responsibility to inform Dr. Head's office of any changes in contact and/or insurance information in a timely manner.**

_____ _____

Patient/Guardian Signature Date

MEDICARE AUTHORIZATION

I request that the payment of authorized Medicare benefits be made on my behalf to Rachel B. Head, MD for any service furnished to me. I authorize my holder of medical information about me to release the Health Care Financing Administration and its Agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Guardian Signature Date

RELEASE OF INFORMATION

I give Dr. Rachel B. Head, MD my authorization to use or disclose my protected health information for use by specialists if referred by my treating physician and understand that it will only contain the minimum health information necessary regarding illness or injury. I further authorize the release of necessary health information concerning my diagnosis and treatment for the purpose of securing payment from my insurance company, and thereby authorize payment of the insurance benefits directly to the doctor for services rendered that are not paid directly to me.

_____ _____

Patient/Guardian Signature Date

ACKNOWLEDGEMENT OF HIPPA PRIVACY PRACTICES

I understand that under the "Health Insurance Portability & Accountability Act of 1996" (HIPPA), that I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to: 1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly; 2) Obtain payment from third party payers; 3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed and had access to Notice of Practices containing a more complete description of the used and disclosures of my health information. I understand that Dr. Rachel B. Head, MD has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time.

_____ _____

Patient/Guardian Signature Date

RACHEL B. HEAD, MD
TELEMEDICINE CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not physically be in the same room as my health care provider. I will be notified of and my consent will be obtained if anyone other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I may revoke my right at any time by contacting Dr. Rachel Head, MD Urology at (936) 305-5109.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.

   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.

   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.

   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Guardian Print Name Date

_____ _____

Patient/Guardian Signature Date

RACHEL B. HEAD, MD
HIPPA AUTHORIZATION TO RELEASE INFORMATION

The authorize the following people permission to discuss and/or obtain my medical records:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

If at any time I wish to add or remove someone from this list, I will notify the office in writing.

_____ _____

Patient/Guardian Signature Date

Rachel B. Head, MD
Urology

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Release my medical records from:

DOCTOR'S NAME: _____

TELEPHONE: _____

FAX: _____

TO:

Rachel B. Head, MD
UROLOGY
617 Russell Blvd.
Nacogdoches, TX 75965
Phone: 936-305-5109
Fax: 936-305-5112

Reason for release of Information:
_____ Medical Care _____ Legal Care _____ Insurance _____ Other

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests. I understand that I may revoke this consent at any time except as to the extent that action has been taken in response to such request. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS") treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be continued by completion of this form. I have read and fully understand the contents of this request. A photo static copy of this form may be used in lieu of the original.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS.

Patient Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____