

Rachel B. Head, MD  
 617 Russell Blvd  
 Nacogdoches, TX 75965  
[www.headurology.com](http://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



**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: \_\_\_\_\_



617 Russell Blvd, Nacogdoches, TX 75965  
P: 936-305-5109 F: 936-305-5112

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Why are you seeing the Doctor Today? \_\_\_\_\_

**ALLERGIES** (please list all types or state NONE):

\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY** Please **CIRCLE** if you **have** or **have had** any of the following:

Cardiovascular

- Anemia
- Angina (Chest Pain)
- Aortic Aneurysm
- Arrhythmia (Irregular Heartbeat)
- Heart Failure
- Blood Clots
- Heart Attack
- High Blood Pressure
- Mitral Valve Prolapse
- Sickle Cell Anemia

GERD (acid reflux)

- Hemorrhoids
- Hepatitis
- Peptic Ulcer
- Ulcerative Colitis

Neuro/Psych

- Alzheimer’s Disease
- Anxiety
- Bi-Polar Disorder
- Depression
- Epilepsy
- Migraine
- Multiple Sclerosis
- Spinal Cord Injury
- Stroke

Endocrine

- Diabetes (non-insulin dependent)
- Diabetes (insulin dependent)
- Gout
- High Thyroid
- Low Thyroid

GU

- AIDS
- Bladder Infection (UTI)
- Erectile Dysfunction
- Hematuria (Blood in Urine)
- Interstitial Cystitis
- Kidney Infection
- Kidney Stones
- Neurogenic Bladder
- Testicular Infection
- Undescended Testicle

Respiratory

- Asthma
- Bronchitis
- COPD
- Pneumonia
- Pulmonary Embolism
- Tuberculosis

General

- Allergies
- Hernia
- High Cholesterol
- Malaise (Weak/Tired)
- Sleep Apnea

GYN/OB

- Endometriosis
- Menopause
- Osteoporosis
- Uterine Fibroids

Tumors

- Bladder Tumor
- Brain Tumor
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Lung Cancer
- Lymphoma
- Melanoma
- Ovarian Cancer
- Prostate Cancer
- Kidney Cancer
- Testicular Cancer

GI

- Gallstones
- Colitis
- Constipation
- Crohn’s Disease
- Diarrhea
- Diverticulosis

HEENT

- Blindness
- Cataracts
- Glaucoma

Musculoskeletal

- Arthritis
- Back Pain
- Fibromyalgia





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SURGICAL HISTORY Please CIRCLE if you have had any of the following surgeries & write the year of the Surgery

Cardiovascular

Aortic Aneurysm Repair  
Bypass Surgery  
Heart (Stents)  
Pacemaker Insertion

GI

Appendectomy  
Bariatric Surgery (Obesity)  
Bowel Resection  
Cholecystectomy (Gallbladder)  
Colonoscopy  
EGD  
Hemorrhoidectomy  
Ileostomy  
Hernia Repair (Location?)  
Splenectomy

GU

Bladder Surgery (Incontinence)  
Bladder Tumor  
Prostate Biopsy  
Circumcision  
Cystoscopy  
Hydrocelectomy

Interstim  
Nephrectomy  
Orchiectomy (testicle removed)  
Removal of Kidney Stones  
Penile Implant  
Radical Prostatectomy  
Shockwave Therapy of Stones  
TUMT (Microwave)  
TURP (Prostate Resection)  
Urinary Stent Placement  
Vasectomy  
VLAP (Laser Ablation of Prostate)

GYN/OB

Breast Surgery  
C-Section  
Hysterectomy  
Oophorectomy (Ovaries)  
Tubal Ligation  
Vaginal Prolapse

HEENT

Cataract Surgery  
Eye Surgery  
Facial Surgery  
Parathyroidectomy

Sinus Surgery  
Thyroid Surgery  
Tonsillectomy

Musculoskeletal

Amputation  
Back Surgery  
Carpal Tunnel Surgery  
Disc Surgery  
Foot Surgery  
Hand Surgery  
Hip Surgery  
Knee Surgery  
Leg Surgery  
Shoulder Surgery  
Spinal Surgery

Respiratory

Lung Surgery/Biopsy

Skin

Melanoma  
Basal Cell Carcinoma  
Skin Grafting  
Squamous Cell Carcinoma

Please write below any medical conditions or surgeries you have had/have that were not listed above:

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**FAMILY HISTORY** (Mother, Father, Siblings, Grandparents, Aunt, Uncle)  
**Please indicate which family member has/had any of the following:**

Bladder Cancer \_\_\_\_\_  
Kidney Cancer \_\_\_\_\_  
Kidney Stones \_\_\_\_\_  
Prostate Cancer \_\_\_\_\_  
Cancer (site unknown) \_\_\_\_\_  
Arthritis \_\_\_\_\_  
Leukemia \_\_\_\_\_  
Crohn's Disease \_\_\_\_\_  
Depression \_\_\_\_\_  
Other \_\_\_\_\_

Malignant Melanoma \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Throat Cancer \_\_\_\_\_  
Gout \_\_\_\_\_  
Pancreatic Cancer \_\_\_\_\_  
Heart Attack \_\_\_\_\_  
Liver Disease \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_  
Stroke \_\_\_\_\_  
Tuberculosis \_\_\_\_\_

**SOCIAL HISTORY**

Marital Status \_\_\_\_\_  
Alcohol Consumption: YES NO if yes, number of drinks per day \_\_\_\_\_ or per week \_\_\_\_\_  
Tobacco Use: YES NO if yes, number of packs per day \_\_\_\_\_  
Previous Tobacco Use: YES NO if yes, number of years smoked \_\_\_\_\_  
Caffeinated beverages consumed in a day (average and type of caffeine) \_\_\_\_\_  
WOMEN: Last Menstrual Period (date) \_\_\_\_\_ Are you Pregnant? YES NO  
Number of Pregnancies: \_\_\_\_\_ Number of Vaginal Deliveries: \_\_\_\_\_  
Occupation: \_\_\_\_\_

List ALL Medications you are currently taking, including over the counter medications and supplements:

DRUG NAME	DOSAGE	HOW OFTEN

Preferred Pharmacy and Location of Pharmacy (example: Walmart on North Street in Nacogdoches)

\_\_\_\_\_