PRIMARY CARE
KEEPING AUSTIN HEALTHY

Robert C. Raley, MD
Aline C. Zeringue, RN, ACNS-BC
Amanda Mishra, RN, ACNS-BC
Eileen M. Costa, APRN, FNP-C

REGISTRATION INFORMATION

Date:_____ Home Phone:_____Cell:_____

Patient Name:_____ Patient Date of Birth:_____

_____ _____
Email Address Social Security #

_____
Mailing Address, Apartment Number, City, State, Zip

_____ _____
Male or Female Single/Married/Widowed/Divorced

Employed by:_____ Occupation: _____

INSURANCE POLICY INFORMATION

Patients are required to present proof of insurance coverage PRIOR to services, otherwise patient will be responsible for full payment of services at time of visit

Primary Insurance Co.:_____ ID#:_____ Group#:_____

Subscriber's Name:_____ Date of Birth:_____ SS#:_____

Secondary Insurance Co.:_____ ID#_____ Group#:_____

LOCAL PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Phone #:_____ City: _____

Relationship to Patient:_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benfits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____to pay and hereby
Name Insurance Company

assign directly to Dr. Robert Raley/ATX Primary Care all benefits, if any, otherwise payable to me for his/her services. I understand that I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Robert Raley/ATX Primary Care will be credited to my account, in accordance with the above said assignment.

Authorized Signature:_____ Date:
_____

MEDICAL HISTORY

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PATIENT NAME:_____ Date of Birth:_____

YOUR MEDICAL HISTORY

Please list any medical (or mental) conditions that have been diagnosed in the past:

_____

_____

_____

Please list any surgeries you have had:

_____ _____

_____ _____

_____ _____

Please list all medications and supplements you take on a daily basis:

Rx Medications	**Supplements/Herbals**	**Other**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any specialists or other doctors you see on a regular basis:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was your last Physical Exam (including complete blood work): _____ Last Pap: _____

Last Mammogram:_____Last Colonoscopy: _____ Last Bone Density Exam: _____

Please list all of your Vaccinations and Date they were administered:

FLU: _____ **TETANUS:**_____ **HEPATITIS B:**_____

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HAVE YOU HAD THE CHICKEN POX: **Y** **N**

Drug Allergies/Reactions Y N

_____

Any recent Hospitalizations:

_____

_____

Your Social History:

Have you ever smoked **Y** **N** Amount _____

Do you consume alcohol **Y** **N** Amount _____

Do you exercise **Y** **N** Amount _____

Your Family History: (Circle all that apply & state relationship to you)

Diabetes _____ Cholesterol _____ Heart _____

Kidney _____ Liver _____ Cancer (Type) _____

Please tell us how you were referred to our office:

I hereby authorize Robert C. Raley, MD/ATX Primary Care (or any covering physician or employee) to furnish to any hospital requesting physician, insurance company or other duty authorized regulating agency, (or their representatives) any and all information, including but not limited to illness, injury, medical history, consultations, test data, prescriptions, treatment information, as well as copies of hospital and other physician's records, insurance correspondence or any other information unless specifically prohibited in writing. A Photostat copy of this authorization shall be considered as effective and valid as the original. I hereby authorize payment of any health insurance benefits to be paid directly to Dr. Raley/ATX Primary Care. I ask that my physician perform any tests, which he feels, in his professional opinion, are medically necessary for my optimum care and treatment. This request shall supersede any and all previous agreements by either physician or myself with other parties that would attempt to limit my care to less than optimum levels. I agree to be fully responsible for any charges that may not be covered by my insurance, as well as, other charges not deemed by my insurance company (or other parties) to in, in their opinion, medically necessary. I understand that I will be responsible for $40 for each returned check. I agree and understand that I will be charged annual interest of 18% on all unpaid account balances 60 days after they have been incurred or 30 days after they have been turned over to my (patient) responsibility, whichever occurs first. In the event my account has to be turned over to an attorney for collection, I will be responsible for any associated attorney fees incurred in collection overdue accounts. This agreement shall renew automatically each year, unless specifically terminated in writing.

Date _____

Patient/Guardian Signature_____

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READ THIS FIRST

Dear Patient,

These **HIPAA** forms are required by law. Here are the instructions:

You must at least look at the **HIPAA Consent** documents. Although you may refuse to sign, that event has to be noted on the documents (by you or us) and filed in your record.

The **Medical and Financial Agreements** section is required by this practice as condition of treatment and must be signed at this time for us to agree to treat you.

Medicare and Tricare Patients: You have additional documents that must be signed every time you have a physical.

We sincerely regret the inconvenience and thank you for understanding.

ATX Primary Care

2301 W. North Loop Blvd. Austin, TX 78756 Office (512) 452-2506 Fax (512) 371-0187 atxprimarycare.com

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Medical and Financial Agreements

I hereby authorize payment of health insurance proceeds to Robert C. Raley, M.D./ATX Primary Care ask that he perform any and all tests which he feels in his professional opinion are medically necessary for my optimum care and treatment. This request supersedes any and all previous agreements by either physician or myself with other parties to limit my care to less than optimum levels. I agree to be fully responsible for any charges that may not be covered by insurance, as well as, other charges that may be deemed by my insurance company (or any other parties) in their opinion, as not medically necessary. I agree to pay $40 for each returned check and agree to pay 18% interest on unpaid balances 60 days after they were incurred, or 30 days after they become patient responsibility. This agreement shall renew each year automatically, unless specifically terminated in writing.

Signature_____**Date** _____

Health Insurance Privacy and Accountability Act (HIPAA) Consent

Notice of Privacy Practices

Effective Date: September 1, 2013

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.

A. **How This Medical Practice May Use or Disclose Your Health Information** This medical practice collects health information about you and stores it in a chart [and on a computer] [and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient---safety activities, their population---based efforts to improve health or reduce health care costs, their protocol development, case management or care---coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice

participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Worker's Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

22. Psychotherapy Notes. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal

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proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

B. **When This Medical Practice May Not Use or Disclose Your Health Information** Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

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6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

   If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer.

D. Changes to this Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add*: We will also post the current notice on our website.]

E. Complaints: Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: U.S. Department of Health and Human Services

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

Printed Name_____Date _____

Signature_____Date _____

Definition of a Well-Care Visit

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Insurance companies and Medicare have defined a well-care visit as a visit for preventative care. These recommendations apply to healthy people without disease or physical symptoms. If tests or services beyond the scope of a well-care visit are provided, then additional charges will be incurred for those services.

The choice to address both well-care and medical issues is offered for the convenience of avoiding 2 visits. You may prefer to address your medical conditions at a separate visit. If so, please advise the medical assistant when you are brought to an exam room.

Please remember that Medicare has its own defined wellness coverage guidelines. Go to http://www.medicare.gov/coverage/preventative-visit-and-yearly-wellness-exams.html to review coverage service requirements.

What is a WELL-CARE Visit?

YES	NO
A review of your current health and medical history	Treatment or consultation for a specific medical condition
Counseling about ways to improve your health	Recommendations for treating a symptom is not considered part of a well-care visit
A physician exam tailored to your preventative care needs	Medication refills for current medical conditions
Immunizations and screening tests, if needed (billed separately)	Disease care/management

Your scheduled appointment today is for an ANNUAL EXAM, which is a well-care visit. Wellness exams are often paid 100% by your insurance company. This is for the purpose of assuring all the recommended health screening tests and procedures have been done. These annual visits are not normally for treating conditions or disease. Unfortunately, it is impossible for us to know your contract with your insurance company; we cannot advise you if your insurance company is going to cover the charge for an annual exam. If tests or services beyond the scope of a well-care visit are provided, then you will incur additional charges.

- If you are uncertain of your coverage, please contact your insurance company regarding benefits
- I fully understand and agree to pay Dr. Robert Raley/ATX Primary Care for this service if my insurance company denies my claim.

SIGNATURE:_____ Date:_____

PRINTED NAME: _____ Date of Birth: _____