1200 East Davis St. Suite 113
Mesquite, TX 75149

PIONEER HEALTHCARE CLINIC
Care With Compassion
A Family Medical Clinic

Phone# (972)-295-9090
Fax# (972) - 534-0010 Registration

Registration Form

GENERAL INFORMATION/ INFORMACION GENERAL **DATE/ Fecha** (mm/dd/yyyy)

Patient's Name: | **Age**

Nombre de paciente Last/Apellido First/ Primero SI | D.O.B/ Fecha de Nacimiento | Edad

Address: | **Phone #/ Numero de telefono**

Direccion: (Street, apt. #)

City: | **State:** | **Zip Code:** | **SSN:** Sex: ◯ M ◯ F

Ciudad | Estado | Codigo postal

Emergency Contact:

Contacto de emergencia | Relationship to patient/Relacion del paciente | Phone #/ Numero de telefono

Name of Insurance: | **Member ID/ Group ID:**

Nombre de seguranza | Identificacion de miembro/ Identificacion de grupo

Preferred Pharmacy: | **E-mail:**

Pharmacia preferida: | Correo electronico

Parent or Legal Guardian: I hereby authorize Pioneer Healthcare Clinic and/ or agents to use my general information (address, phone (text messages), and email) to contact me to facilitate anything related to my medical care.
Paciente o Tutor: Autorizo el use de mi informacion general (direccion, telefono (mensajes de texto), y correo electronico) para ser contactado por Pioneer Healthcare Clinic y/o agentes para facilitar el siguimiento de mi cuidado medico.

PERSONAL RESPONSIBLE FOR PAYMENT/ PERSONA RESPONSIBLE DE PAGO

Relationship to patient/ Relacion a Paciente
◯ Mother/ Madre ◯ Father/ Padre ◯ Father/ Padre

Last Name | First and Middle Name

Apellido | Primer y Segundo Nombre

SSN: ◯ M ◯ F | **Age**

D.O.B/ Fecha de Nacimiento | Edad

Address: | **Employment/Trabajo:**

Direccion: (Street, apt. #)

City: | **State:** | **Zip Code:**

Ciudad | Estado | Codigo postal | Work phone/ Numero de telefono de trabajo

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to Pioneer Healthcare Clinic for any services furnished me by that provider. I authorized medical information needed to determine these benefits or the benefits payable for the related services to be released to the insurance company and its agents. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services. Please note: It is the policy of this office that any parent who requests treatment for the child is responsible for the payment of all subsequent fees.
Solicito que el pago de las presentaciones de seguros autorizadas de cualquier compania de seguro aplicables se hagan en mi nombre a Pioneer Healthcare Clinic para todos los servicios prestados por mi a ese proveedor. Yo autorize la informacion medica necesaria para determinar estos beneficios o, los beneficios pagaderos por los servicios relacionados sean entregados a la compania de seguros y sus agentes. Entiendo de incluso pense que tener algun tipo de cobertura de seguro, yo soy responsible del pago de los servicios. Tenga en cuenta, es la politica de esta oficina que qualquier padre se solicita tratamiento para el nino es responsible del pago de los servicios del pago de todas las cuotas subsiguentes.

Name/Nombre: | Signature/Firma:

Relationship/Relacion: | Date/ Fecha:

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Patient Name: _____ DOB: _____

Medicare Assignment of benefits to Statement to Permit of Heath and/or Medical insurance benefits To Pioneer Healthcare Clinic and Providers

I certify that the information given by me in applying for payment under title XVLlll of the Social Security Act is correct. I authorize any holder of medical or other information about me to the centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed or for this or a related Medical claim. I request that payment of authorized benefits be made on my behalf.I assign the benefits payable for physician and / or mid level (Nurse Practitioner or Physician Assistant) provider services to the provider or organization furnishing the services or authorized such provider or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for any health insurance deductibles and co insurance.

FINANCIAL RESPONSIBLITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for all services rendered and I agree to honor the current Clinic payment policy. I understand that, in the unable to pay in full at the time service is rendered; Pioneer Healthcare Clinic may inquiry of my credit history to evaluate my credit worthiness. I further understand that unpaid patient accounts may accrue interest (1.5%)per month/ 18% per year) and I agree to pay any such interest charges in addition to any amount unpaid by any insurance coverage. I further understand that should this account become delinquent and it becomes necessary for the account to be referred to as attorney or collection agency for collection suit, I agree to pay all reasonable attorney fees and/ or collection expense.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby irrevocably assign and transfer to Pioneer Healthcare Clinic, Mesquite, Texas any benefits under hospitalization, sickness liability, auto or accident insurance, and any other coverage for the payment of such services rendered. I agree to cooperate, aid and assist the clinic in procuring all possible insurance benefits, including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I understand it is my responsibility to the provider for charges not paid pursuant to this assignment.

AUTHORIZATION FOR CARE

I hereby authorize the staff of Pioneer Healthcare Clinic to administer such care/ treatment as it is necessary based on the clinical providers assessment and diagnosis. I understand that such care may include medical and surgical treatment, and laboratory, and radiologic test. I certify that no guarantee of assurance has been made to the results that may be obtained.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize staff of Pioneer Healthcare Clinic to disclose necessary information from my medical record to the following parties when requested for the purpose as stated herein: to any health care provider for the purpose of providing continuing professional care and to any insurance company or third party payer (or their agent/s) for the purpose of obtaining payment to employees, offices and attending clinical providers are released from legal responsibility or liability for the above information to the extent indicated and authorized herein. I understand this released specifically includes any and all blood and related tests including test results reflecting presence of HIV, HBV and other diseases, all of which I specifically authorize to be so released.

_____	_____	_____
Signature of Patient or Representative	Relationship to patient	Date
_____	_____	_____
Responsible Party (if different)	Relationship to patient	Date

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Advanced practice nurses Consent for Medical Treatment

Pioneer Healthcare Clinic has an advanced practice nurse to assist in the delivery of primary health care. Pioneer Healthcare Clinic is a family medical clinic that is owned and operated by Vishnu Maya Upadhyay, a certified family and women's health nurse practitioner.

A nurse practitioner is a registered nurse (RN), also known as nurse practitioners (ANP) has a Masters Degree in Nursing and a board certification in their specialty. They have education and training in specialty areas such as family practice, women's health or pediatrics. Family Nurse Practitioners have acquired the necessary knowledge and expertise, skills and training in the care of people of all ages. I have read this document and hereby confine the services of a nurse practitioner for my health care needs.

Patient's Name

Date

Patient's Signature

Date of Birth

Parent/ Guardian Signature and Date

How did you hear about us?

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Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies, and others, put in place controls to ensure the your personal medical information is safe.

Pioneer Healthcare Clinic requires that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company.

By signing this form, consent to our use and disclosure of protected health information about your treatment, payment, and health care operation. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient: _____ **Date:** _____

Name of Patient: _____ **Date of birth:** _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or other to call and request the results of tests and procedures. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to a family member you must sign this form. Signing this form will only give consent to release laboratory and radiology results to family members indicated below. This consent will not allow Pioneer Healthcare Clinic Associates to release any other information to these family members.

You have the right to revoke this consent in writing, except where we have already made disclosures in reliance to your prior consent.

1.) _____ Relation to patient: _____ Date: _____

2.) _____ Relation to patient: _____ Date: _____

Patient name: _____ **Patient Signature:** _____ **Date:** _____

Authorization to Leave Messages with Household Members/ Answering Machine

From time to time it is necessary for representatives of Pioneer Healthcare Clinic to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that medical staff would like to discuss lab or procedure results, or to ask a patient to call CMC regarding an issue or concern. The purpose of this consent is to leave massages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient name: _____ **Date:** _____

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Consent and acknowledgement of Receipt of Privacy Notice

I understand that as part of provision of healthcare service, Pioneer Healthcare Clinic, create and maintain health record and other information describing among other things, my health history symptoms, diagnosis, treatment, examination, and test results, prescription drug history, and any plans for future care or treatment.

I have been provided with a notice of privacy practice that provides a more description of the use and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of revised notice to the address I have provided. I understand that I have the right to request restriction as to how my information may be used or disclosed to carry out treatment, payment or healthcare operation (Quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restriction requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:
1.Any and all records, where written or oral in electronic format, are confidential and cannot be discussed for reasons outside of treatment, payment or healthcare operation without my prior written authorization, except as otherwise provided by law.
2.A photocopy or fax of this consent is as valid as the original.
3.I have the right to request that the use of my protected health information, which is or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that Pioneer Healthcare Clinic and I must agree to any restriction in writing that I requested on the use and disclosure of my protected information which have been previously agreed upon.

Full Name

Date

Signature

Date of Birth

Guardians Signature (if child)