EASTSIDE CLINIC & WELLNESS CENTER, PLLC

REGISTRATION FORM

Today's date: | PCP: GRACIELA LEIJA, MD

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. ❑ Miss ❑ Other | Marital status (circle one) Single / Mar / Div / Sep / Wd

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth Date: / / | Age: | Sex: ❑ M ❑ F

Street Address: | Social Security No: | Cell / Home phone no: ( )

P.O. box: | City: | State: | Zip Code:

Occupation: | Employer: | Employer phone no: ( )

¿Chose clinic because / Referred to clinic by (please check one) ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home / work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsable for bill: | Birth Date: / / | Address (if different): | Cell / Home phone no: ( )

¿Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber name: | Subscriber's S.S. no: | Birth Date: / / ❑ Child | Policy no: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Policy no: ❑ Child

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Other

PHARMACY TO SEND PRESCRIPTIONS	ADDRESS & PHONE NUMBER

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Phone no: ( ) ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinic. I understand that I am financially responsible for any balance. I also authorize EASTSIDE CLINIC & WELLNESS CENTER or insurance company to release any information required to process my claims and to also acquire my Rx history from other providers and/or pharmacies.

Patient/Guardian Signature ***Date***

AUTHORIZATION TO LEAVE PERSONAL
HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name: _____ DOB: _____

From time to time it may be necessary for a representative of Eastside Clinic & Wellness Center, PLLC to contact patients for various notification purposes that could include Protected Health Information such as:

- Appointment reminders/confirmation/rescheduling
- Prescription renewal/reminder information
- Lab test results
- Requests to call the doctor for other issues

We would like to know how we can contact you and with whom we can leave a message or share information about your Protected Health Information.

I authorize Eastside Clinic & Wellness Center physicians and/or staff to contact and leave messages that could include Protected Health Information pertaining to my care by the means selected below.

Check and all that apply:

	Method	Number w/ Area Code/Email Address
	Home telephone/voice msg	
	Cell Phone/voice msg	
	Work telephone/voice msg	
	Email	
	Other	

AUTHORIZATION TO SHARE PERSONAL
HEALTH INFORMATION WITH CERTAIN INDIVIDUALS

In addition, I give permission for the following individuals to receive my Protected Health Information:

Name	Relationship	Number w/ Area Code

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until I make any changes in writing. It is my responsibility to notify Eastside Clinic & Wellness Center in writing if I want to change any of the information noted above.

X _____

Patient or Legally Authorized Representative Signature Date

CONSENT FOR TELEMEDICINE HEALTH SERVICES

Patient Name: _____ Date of Birth: _____

Provider Name and Location: **Eastside Clinic & Wellness Center, PLLC, Austin, Texas**

Introduction

Telehealth utilizes interactive video & voice conferencing that enables Eastside Clinic's providers to provide health services to their patients remotely. I understand that this visit will not be the same as a face to face assessment since the patient will not be in the same location as the provider.

During the telemedicine health service:

- Details of my medical history including, but not limited to, medical reports, medication information, and critical incident reports may be discussed.
- Visual and physical examination of my body may take place.
- Nonmedical personnel may be requested to enter the area where telemedicine is being performed to assist in operating video conferencing equipment; and
- Video, audio, and/or photo recordings will not be taken during the assessment.

Privacy

All existing laws regarding privacy and security of my health information and copies of my medical records apply to this telemedicine health service and the audio and video information transmitted and received electronically as part of this service. Any dissemination of patient-identifiable images or information from this telemedicine interaction to researchers or other entities for purposes other than my treatment, payment of healthcare services I receive, and certain necessary administrative and operational activities supporting my care shall not occur without my authorization.

Considerations

As with any health services, there are considerations associated with the use of telemedicine. These include, but may not be limited to:

- In certain cases, information may not be enough to render health services.
- Delays in health services may occur due to interruptions and/or failures of the equipment.
- At any time, I may choose to stop telemedicine health services.
- Stopping the telemedicine health services may cause additional delays.

Consent

I agree that I have received an explanation of how the video and audio technology will be used to conduct the telemedicine health service, and I understand there are limitations to the technology and the process of telemedicine, including the potential for incomplete exchange or loss of information. I understand and consent to participate in the telemedicine health service. I understand the written information provided above, and I hereby voluntarily and freely agree and give my consent to take part in the telemedicine health service and any related evaluation, assessment, and diagnosis as the consulting health care provider deems appropriate for my current medical condition.

Signature: _____ Date: _____

Financial Policy for Eastside Clinic & Wellness Center, PLLC

Patient Name:_____ **DOB:**_____

Welcome to **Eastside Clinic & Wellness Center, PLLC.** In order for us to be able to deliver the quality of care that you are accustomed to; we have established our financial policies. The following is a list of guidelines that are necessary in order to continue to provide high quality care and make your visit as pleasant as possible.

PLEASE READ ALL INFORMATION AND ACKNOWLEDGE BY SIGNING BELOW.

1. We ask that you present your insurance card at each visit. It is your responsability to provide us with the correct information to bill your insurance.

2. If you have a change of address, telephone numbers, or employer, please notify the receptionist and we will update your information.

3. We will collect your deductible, co-payment, or charge for non-covered services at the time of your visit. If you have a balance after an insurance payment from a previous service, we will also ask for that payment. We accept cash, checks, money orders and credit cards.

4. If we do not participate with your insurance, we will file your claims as a coutesy. you will be expected to follow-up to make sure payment is made to us in a timely manner. If we do not receive payment from them within 45 days, you will be billed for any unpaid balance. If we are not providers for your insurance then payment is expected at the time of service.

5. **MEDICARE PATIENTS:** We will bill Medicare part B for all your covered charges. If you have a supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of the amount allowed by Medicare) wil be collected at the time of service. Each year Medicare has a deductible you will be expected to pay until your deductible is met.

6. **HMO-PPO PATIENTS:** If we participate with your plan we will bill your insurance for you. Payment will be collected at the time of service-no exceptions. If your plan requires you to have an authorization to see a specialist, you will need to obtain that from your primary care physician prior to be seen in Eastside Clinic & Wellness Center, PLLC. If we do not participate with your plan, we will verify your out-of-network benefits, file your charges, and will expect payment of your portion of the charges at the time of service.

7. **SELF-PAY PATIENTS:** Patients with no insurance will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor/nurse practitioner to make payment arrangements.

8. **NO SHOW OR MISSED APPOINTMENTS:** When an appointment is scheduled with the doctor, time is specifically allocated for you. We understand there may be a time when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel an appointment by you at least 24 hours before the appointment.

If you have any questions regarding our financial policy, please contact our billing department at (512)363-5725.

I have read and have full understanding of the financial policy for Eastside Clinic & Wellness Center, PLLC.

Patient Signature:_____ **Date:**_____

EASTSIDE CLINIC & WELLNESS CENTER, PLLC

PRESCRIBING POLICY

There is an urgent health crisis facing our country. Over the last 15 years, there has been a major increase in deaths and overdoses from prescription drugs across the United States. To ensure the health and safety of our patients and reduce the risk of adverse events, Eastside Clinic has this prescribing policy effective immediately:

1. **Prescribers are prohibited from prescribing Control II medications, including opioid/opiate narcotics.**
   - Patients in need of these medications will be referred to Pain Management for further evaluation and treatment.

2. **Prescribers are prohibited from prescribing sedatives/hypnotics/anxiolytics (e.g., benzodiazepines or barbiturates) due to the potential risk of respiratory suppression.**
   - Patients in need of these medications will be referred to Psychiatry for medication management and treatment.

3. **Prescribers are prohibited from prescribing Schedule IIN stimulants including: amphetamine (Dexedrine, Adderall), methamphetamine (Desoxyn), and methylphenidate (Ritalin).**
   - Patients in need of these medications will be referred to Psychiatry and/or Neurology for medication management and treatment.

I HAVE READ AND UNDERSTAND THE PRESCRIBING POLICY ABOVE.

Signature: _____ Date: _____

Name: _____