# Austin OB/GYN
# Jeff E. Hagen M.D.

## Patient Registration Form

Last Name: _____ First Name: _____ Middle: _____
Address: _____ Apt. #_____
City: _____ State: _____ Zip Code: _____
Home PH: _____ Work PH: _____ Cell PH: _____
SSN: __ __ __ - __ __ - __ __ __ __ Date of Birth: _____ /_____ /_____ Age: _____
Status: Single Married Widow Divorced
Occupation: _____ Employer: _____
Emergency Contact Person: _____ Phone Number: _____
E-Mail Address:_____

## Guarantor Information (Patient's age 18 & under)

Last Name: _____ First Name: _____ Middle: _____
Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Relationship to patient: _____ SSN: __ __ __ - __ __ - __ __ __ __ Age: _____
DOB: ____/____/____ Home PH: _____Cell PH: _____Work PH: _____
Status: Single Married Widow Divorced
Occupation: _____ Employer: _____

## Insurance Information

Name of Insurance Company: _____
Identification no._____Group no._____
Insurance Policy Holders Full Name: _____
Mailing Address: _____City: _____State: _____ Zip Code: _____
Policy Holders SSN: __ __ __ - __ __ - __ __ __ __ Policy Holders DOB: ____ / ____ / ____
Relationship to the patient: _____ Employer: _____

## Authorization Responsibility Agreement

Payment is due at time of service. If we are providers for your insurance, we will bill your insurance and collect only your co-pay portion at the time of service. Many insurance plans have "timely filing deadlines". Accurate information to bill your claim must be provided on the date of your visit or you may be responsible for payment in full for services rendered to you. Insurance can vary in coverage of preventative care, physicals & immunizations. Please verify all coverage options with your plan before scheduling any of these services. Patients will be billed for the balance of any non-covered services. I authorize medical care and accept the financial responsibility for myself and my minor children. I am responsible for all fees regarding my health care, and will make sure the charges are paid in a reasonable time. I hereby authorize the release of any medical or other information necessary to process any claims.

_____ _____

301 Hwy 71 W Suite 111 ● Bastrop, TX 78602
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Signature of Patient authorized representative Today's Date

## PATIENT CONFIDENTIALITY

There are times when we will need to communicate with you by telephone. We are legally and ethically obligated to share any and all information related to patient care only with those persons specifically authorized by the patient or person legally responsible for the patient. Please complete and sign the questionnaire below so we are very clear about your wishes in this regard.

1. May we leave confidential information such as lab results, including abnormal results on your:

   Answering machine at home? Yes No N/A

   Voice mail system at work or on a cell phone? Yes No N/A

2. Please list below the names of people we may give confidential information:

   _____ _____
   Name Relationship to patient

   _____ _____
   Name Relationship to patient

   _____ _____
   Signature of patient or responsible party Date

Please list two names of whom we can contact in case of an emergency:

1. _____
   Name & phone number

2. _____
   Name & phone number

***Do you have a living will? Yes / No**

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## Nurse Practitioner and or Physician Assistant
## Consent for Treatment

This facility has on staff a nurse practitioner and physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

A nurse practitioner is not a doctor. A nurse practitioner is a registered nurse who has received advanced education and training in the provision of health care. A nurse practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

Supervision does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

I have read the above, and hereby consent to the services of the nurse practitioner or physician assistant for my health care needs.

I understand that at any time, I can refuse to see the nurse practitioner or physician assistant and request to see our physician Dr. Jeff Hagen. Please make this request known when scheduling your appointment.

Name (printed):_____

Signature: _____ Date: _____

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Privacy Practices Acknowledgement Form

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. Please note that attached is a copy of the Notice Of Privacy Practices document.

Name: _____ DOB:_____

Signature:_____ Date:_____

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## FINANCIAL POLICY:

Patient's Name: _____ Date of Birth: _____

**BASIC POLICY:** Pay for service is due in full at the time service is provided in our office. We accept cash, credit cards, and personal checks no greater than $50.

**FOR PATIENTS WITH INSURANCE:** We bill most insurance carriers for you if proper paperwork is provided to us, however all secondary insurance billing will be the patient's responsibility. The only exception in Medicare patients who have arranged for automatic crossover of claims. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. It has been explained to me that insurance companies have a disclaimer stating that all claims will be processed according to plan provisions at the time they receive the claim and there is no guarantee of coverage. I understand that my account is my responsibility regardless of insurance. I agree to pay all bills that are not covered under my insurance or vary from what my plan benefits state. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Please note: Verification of coverage is not a guarantee of payment. You will be considered responsible for all visits, labs, and procedures not covered by your insurance.

**STATEMENT FEE: Please note: there will be a $5.00 statement fee added to your account if our office needs to send a second statement to collect a balance.**

**COLLECTIONS: Bills not paid after three attempts will be sent to a Collection Agency.**

**A 25% interest rate for the processing Fee will be accessed on any account referred for collection.**

**MEDICARE PATIENTS:** We ACCEPT assignment with Medicare. We will bill Medicare for you. We do not bill secondary insurance; the only exception will be if you have arranged for automatic crossover claims. All fees are due and payable at the time service is provided.

**SELF PAY PATIENTS**: We will accept you as a self-pay patient, which you will need to pay for all services in full at the time of service is provided in our office.

**PLEASE BE AWARE THAT IF YOU OBTAIN MEDICAID AFTER THE DAY OF SERVICE OR YOU FAIL TO NOTIFY US THAT YOU HAVE MEDICAID ON THE DAY OF SERVICE, THIS OFFICE DOES NOT ACCEPT RETRO-ACTIVE MEDICAID THEREFORE WE WILL NOT BILL MEDICAID FOR THE SERVICES PROVIDED AND YOU WILL NOT BE ISSUED A REIMBURSEMENT. ANY FURTHER OFFICE VISITS WILL BE BILLED TO MEDICAID AND YOU WILL BE REQUIRED TO FOLLOW THE MEDICAID PATIENT POLICY. _____ PT INITIALS**

**MEDICAID PATIENTS:** All Medicaid patients must provide a current insurance card at all visits.

**SURGERY FEES:** All co pays, deductibles, and payments for surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

**NONCOVERED SERVICES:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

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**PERSONAL INJURY CASES**: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

**YEARLY HEALTH CHECKS**: Periodic preventive health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.

**MISSED APPOINTMENTS:** In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. **There will be a charge of $20.00 for missed appointments.**

**RETURNED CHECK POLICY**

NSF checks will require complete payment in cash for the amount of the check and a $30 fee.

**COPYING CHARTS:** Copying cost as follows: $25

| |
|---|
| **MEDICARE PATIENTS: SIGNATURE ON FILE** I request payment of authorized Medicare benefits be made either to me or on my behalf to Jeff E. Hagen, MD for any services furnished me by the listed provider/supplier. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. |
| I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. |
| Patient's Name (Please Print): Jeff E. Hagen, M.D. |
| Patient's Signature: Date: |
| Patient's Medicare No.: |

**ASSIGNMENT OF INSURANCE BENEFITS:**

**PATIENTS WITH INSURANCE:** Please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **JEFF E. HAGEN, MD**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.

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**The patient is ultimately responsible for all professional fees.**

Signature: _____ Date: _____

**Notice of Privacy Practices**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

**OUR LEGAL DUTY:**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 06/01/2004 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Operations: We may use and disclose your health information in connection with your healthcare operations. Healthcare operations include quality assessment and improve activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Disclosure and Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. We will not see your health information for marketing communications without your written authorization.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons involved in care: we may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Legal requirements: We may use or disclose your health information when we are requested to do so by law.

Abuse or Neglect: We are permitted to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Security Issues: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, or letters).

**PATIENT RIGHTS UNDER HIPAA**

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you $0 - $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for at least 6 years. If you request this accounting information more than once in a 12-month-period, we may charge you a reasonable, cot-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication of confidential information: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions and complaints: If you want more information about our privacy practices or has questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have communicate with you by alternative means or at alternative locations, you may complain to us using the information listed at the end of this Notice. You also may submit a written complaint to the U. S Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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**Contact Officer: OFFICE MANAGER**
**Telephone: 512-304-0318**
**Address: 301 HWY 71 W. Ste. 111 Bastrop, TX 78602**

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