PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ BEING SEEN TODAY

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Alt/Cell Phone: (___) _____ Day Phone: (___) _____ Email: _____

Race _____ Language _____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ (NAME) _____ (RELATIONSHIP) (___) _____ (EMERGENCY CONTACT #)

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ (SPECIFY) Resp. Party SS #: _____

Name: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (MM / DD / YY DATE OF BIRTH) ___ (AGE) S M D W O (MARITAL STATUS)

Address: _____ (MAILING ADDRESS) _____ (APARTMENT) _____ (CITY) ___ (ST) _____ (ZIP) (___) _____ (HOME PHONE)

Full-Time Part-Time Retired Unemployed Student (EMPLOYMENT STATUS (PLEASE CIRCLE ONE)) Employer's Name: or School _____

Employer's Address: _____ (MAILING ADDRESS) _____ (CITY) ___ (ST) _____ (ZIP)

Occupation: _____ (___) _____ (WORK PHONE) (___) (EXT)

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ (DATE OF BIRTH) Spouse's Work Phone: (___) _____ (___) (EXT) Occupation: _____

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (STREET or P.O. BOX) (___) _____ (PHONE)

Co-Pay Amount: (if applicable) _____ _____ (CITY) ___ (ST) _____ (ZIP)

Primary Care Physician: _____

Policy Holder: _____ (LAST) _____ (FIRST) ___ (MI) ___ (SEX) ___/___/___ (DATE OF BIRTH) _____ (SS #)

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____ (SPECIFY)

Employer's Name: _____ _____ (INSUREDS ID) _____ (GROUP NAME AND/OR NUMBER)

Address: _____ (STREET) _____ (CITY) ___ (ST) _____ (ZIP)

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____ Adj. _____

Address: _____ City: _____ State _____ Zip _____ Phone _____

Claim #: _____ DOI _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE DATE

PHARMACY INFORMATION

Preferred Pharmacy: _____

Address: _____

Phone: _____

Do you use a mail order pharmacy? If yes, please indicate. _____

MEDICATIONS LIST

Are you currently taking any medications? Circle: Y / N

Medication Name	Dosage	Frequency

MEDICATION AND FOOD ALLERGIES

Are you allergic to any foods or medications? Circle: Y / N

Food or Medication	Reaction(s)	Severity

PREVENTATIVE TESTING

Test	Date	Abnormal? Write Y or N.
None		
Cardiac Stress Test		
Colonoscopy		
DEXA Scan/Bone Density Test		
Echocardiogram		
Annual Physical Exam		
Pulmonary Function Test		
Mammogram		
PAP Smear		
Eye Exam		
EKG		
Bloodwork		

MEDICAL HISTORY			
Condition	**Year**	**Condition**	**Year**
None		Liver Disease	
Allergies		Migraine Headaches	
Anemia		Myocardial Infarction (Heart Attack)	
Angina		Obesity	
Anxiety		Osteoarthritis	
Arthritis		Osteoporosis	
Asthma		Peptic Ulcer Disease	
Atrial Fibrillation		Pneumonia/TB	
Benign Prostatic Hypertrophy		Renal (Kidney) Disease	
Cancer – Type:		Seizure Disorder	
Stroke/TIA		Stomach Ulcer	
Coronary Artery Disease/CHF		Thyroid Disease	
COPD		Other:	
Crohn's Disease			
Dementia/Alzheimer's			
Depression			
Diabetes: Type 1 or Type 2			
Gallbladder Disease			
GERD (Reflux)			
Glaucoma/Cataracts			
Hepatitis C			
Hyperlipidemia (High Cholesterol)			
Hypertension (High Blood Pressure)			
Insomnia			
Irritable Bowel Disease			

FAMILY HISTORY					
Diagnosis	Mother	Father	Brother	Sister	Other
Alive and Well					
Deceased – Age:					
No pertinent info known					
Alcoholism					
Alzheimer's Disease					
Asthma					
Blood Disease					
CAD (Heart Attack)					
Cancer – Type:					
CVA (Stroke)					
Depression					
Developmental Delay					
Diabetes					
Hearing Deficiency					
Hyperlipidemia (High Cholesterol)					
Hypertension (High Blood Pressure)					
Irritable Bowel Syndrome					
Learning Disability					
Mental Illness					
Tuberculosis					
Obesity					
Osteoarthritis					
Osteoporosis					
PVD (Peripheral Vascular Disease)					
Renal Disease					
Other:					

SOCIAL HISTORY

Tobacco Use – *Circle what applies:*

Never Daily Weekly Less Year Quit/Pack Year:

Alcohol Use – *Circle what applies:*

Never Daily Weekly Less Year Quit:

Exercise Activity – *Circle what applies:*

Sedentary Moderate Vigorous

Caffeine Use – *Circle what applies:*

Never Daily Weekly

Privia Medical Group North Texas

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: _____
  - ☐ OK to leave a message with detailed information
  - ☐ Leave name and doctor with call back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: _____

I consent and authorize the release of NORMAL test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize the release of ABNORMAL test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: _____
- ☐ My children: _____
- ☐ My parents: _____
- ☐ Other: _____

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

☐ Yes ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

☐ Yes ☐ No

Do you have an advanced directive (Living Will)?

☐ Yes ☐ No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

☐ Yes ☐ No

_____

Patient Signature (Must be an adult 18 yrs or older) Date

_____

Print Name Birthdate

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date #_____

_____ _____

Date *Patient/Legal Representative*

THCOBP12

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's 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.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

NAME: _____ DATE: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle the answer that pertains to you.

	Never	Sometimes	Frequently	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself; or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3
Add columns:				
Total:				

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____
Very difficult _____ Extremely difficult _____

PRIVIA
MEDICAL GROUP

FINANCIAL POLICY

Welcome to Privia Medical Group! We are pleased that you have chosen us as your health care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. This form confirms that you understand that the services provided are necessary and appropriate, and advises you of your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding patient responsibility; in that case, you will be asked to save a credit card on file to settle your account or pay a deposit when you check in or out.

If you save a credit card on file, we will charge your card for the balance due when your insurance company notifies us of your patient responsibility. When you make a deposit, you will pay an estimate of the expected patient responsibility; when your insurance company notifies us of your patient responsibility, we will either send you a statement for the balance due or issue a refund.

If you have an Annual Wellness Visit or Physical Exam but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, payment plans are available.

TYPES OF PAYMENTS

1. Co-payments. Insurance carriers require that we collect your co-payment at the time of your visit. If you are not prepared to make your co-payment, you may reschedule your appointment.

2. Deductibles. Most insurance plans require you to pay a predetermined amount (the "deductible") before insurance will cover certain charges. Our technology allows us to view your remaining deductible and help you understand what you will owe for your visit so we can collect the amount due at the time of your visit. For new patients who have not yet met their deductible, we may collect up to $125.00; for established patients, we may collect up to $75.00. This payment will be applied to your visit. When your insurance completes processing of your health insurance claim, you may be responsible for an additional amount depending on our contract with your insurer.
NOTE: If you use our Card on File process, you will *not* be required to pay a deposit at the time of your visit.

3. Co-insurance. Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. Our technology allows us to view the details of your insurance plan, including your coinsurance amount, and calculate the expected out-of-pocket cost for you. If we can determine the amount, we will ask that you pay your co-insurance at the time of your visit.

4. Uninsured Patients / Self-Pay. If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit. Two options are available: 1) a prompt pay discount is available if you pay in full at the time of service; or 2) we can bill you if you do not pay at the time of service. If the total charge amount is not available at the time of checkout, you may be

required to pay a deposit that will be applied to your charges. If the deposit exceeds actual charges then a refund will be issued.

Deposit amounts are:

- *New patients*: total charge or a minimum $200 deposit.
- *Established patients*: total charge or a minimum $150 deposit.
- *Procedures:* total charge or a minimum $200 payment

5. Out-of-Network. We participate with most major insurance plans. You should contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service. We may send a courtesy bill to your insurance company. If the total charge amount is not available at the time of check out, you may be required to pay a deposit as described above.

6. Non-Covered Services. It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, you are expected to pay for the services at the time of your visit. Our billing staff will assist you in attempting to resolve any appeals.

If you are a Medicare patient, we will inform you of any non-covered services prior to your treatment. Your provider will review options with you and document your decision and acceptance of financial responsibility using the Centers for Medicare and Medicaid Services (CMS) form CMS-R-131 (03/08), Advance Beneficiary Notice (ABN).

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). If you provide your insurance card(s) at a later time, we may be able to retroactively bill the services to your insurer depending on the insurance plan's requirements. We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology, or other diagnostic related providers.

You are responsible to:

- Know if a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- Check with your insurance plan to determine if prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Check with your insurance plan to review the schedule of benefits and whether a co-payment or deductible applies.
- Fully cooperate and provide necessary assistance for us to file any appeals with your insurance plan.
- Coordinate benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or to correct any demographic or other issues.
- Arrive for appointments with all required documentation.

Insurance Verification. We will attempt to verify your insurance eligibility prior to your visit. If we are unable to confirm active insurance coverage, we will contact you about your insurance eligibility. If you are unable to provide information about other active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same day appointments, we will check eligibility when the appointment is made.

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We usually send out statements every twenty-eight (28) days, beginning when the balance becomes the patient's responsibility.
All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal. **If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed.** In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS

Late arrivals. If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule.

Cancellations. If you are unable to keep a scheduled appointment, you must call at least one (1) business day in advance or we may consider you a "no-show."

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

If permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

Thank you for helping us run a better practice!