

PATIENT CONSENT FORM

PATIENT CONSENT FOR TREATMENT

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Hunt Regional Medical Partners and its associated physicians, clinician and other personnel. I am aware that the practice of medicine and other healthcare professionals is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and healthcare operations consistent with the Hunt Regional Medical Partners Privacy Practices.
3. I have been educated and understand that my health information will be shared through the Healthcare Access San Antonio (HASA) Health Information Exchange (HIE) unless I choose to opt out by signing the opt-out request form.
4. I authorize payment of medical benefits to Hunt Regional Medical Partners or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

Signature of Patient or Patient Representative

Date

PATIENT MEDICATION CONSENT

I do hereby give Hunt Regional Medical Partners consent to access my medication history electronically.

I understand that electronically accessing my medication history allows my doctor to receive critically important information on my current and past prescriptions and to become better informed about potential medication issues.

Pharmacy Name(s): _____

Pharmacy Location and Phone Number (if known): _____

Signature of Patient or Patient Representative

Date



GENERAL OFFICE POLICIES

Hunt Regional Medical Partners is committed to providing the highest quality care in the most positive, efficient environment. Every patient, including you, deserves our undivided attention. To accomplish this goal, we find it necessary for patients and staff to follow some simple office policies.

1. Please arrive on time for your appointments. If you find that you may arrive late, please contact our office to confirm you can be worked in after your scheduled appointment time.
2. If you find it necessary to reschedule, please do so at least 24-hours prior to your appointment time. We may find it necessary to charge your account 25.00 for a missed appointment if you do not provide 24-hours notice.
3. To process your refill requests timely, we ask that you follow these steps:
 - a. Routine prescription refills require 48-hours to approve. Please notify our office at least two days in advance so your refill is ready at the pharmacy when you need it
 - b. For existing prescription refills, please contact your pharmacy first, even if you are out of refills. Your pharmacy will contact us
 - c. For problems with a new or existing prescription, contact our office. You will be routed to our "NURSE LINE." Please leave a message on the voice mail and your message will be attended to within 48-hours. This line is monitored throughout the day
 - d. For problems with any prescription that is of an urgent need and cannot wait, please let the front office know at the time of your call that you do not want to be transferred to our NURSE LINE. You will be accommodated if it is an urgent request
4. Please notify the medical assistant of any medication changes, even if prescribed by another provider. It is imperative that your electronic health record with us be as current and accurate as possible, so that we can appropriately care for you.

While we understand the time sensitive nature of refilling prescriptions, we ask that you limit urgent immediate prescription issue requests to those that are actually urgent.

5. Payments are due at the time of visit. This includes coinsurances, estimated and confirmed deductibles, and self-pay payments. For your convenience, we accept cash, check, American Express, Discover, MasterCard, and Visa.
6. Please provide the front office with updated insurance, address, phone, and other changes at the first appointment after the change. Failure to provide this information may result in unnecessary patient liability for payment.

RESCHEDULE, CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel or reschedule your appointment. It is requested that if you must cancel or reschedule your appointment you provide at least 24 hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments and procedures which are cancelled or rescheduled with less than 24 hours notification may be subject to a **\$25.00** fee. This fee will be required to be paid prior to another appointment being scheduled for the patient.

Patients who do not show up for their appointment or procedure and do not call to cancel or reschedule their appointment will be considered a **NO SHOW**. Patients who **no show** two (2) or more times in a 12 month period, may be dismissed from the practice and denied any future appointments. Patients that **no show** will also be subject to the **\$25.00** cancellation fee.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about our cancellation, reschedule, and no show fees can be directed to our Billing Department (903) 408-5805.

I have read these policies and agree that they are an established part of this practice:

Patient/Guardian Signature

Date



FINANCIAL POLICY AND DISCLOSURE

Hunt Regional Medical Partners strives to collect the appropriate co-insurances due at the time of your visit or prior to your procedure.

In some cases, it is not possible to determine the exact amount of financial liability the patient will have at the time services are rendered.

Hunt Regional Medical Partners has a formula we use to estimate the amount we expect the patient will be responsible for according to the insurance benefits. Benefits are verified routinely.

Please be advised that the amount we collect at any given time may be an estimate based on the information available at the time the insurance benefits were verified.

It is possible that your insurance company will deem a different amount due by you than what was initially collected, for services rendered by our office.

If we receive an explanation of benefits from your insurance company that reflects a higher amount due from you, we will be obligated to collect the remaining amount. This additional amount may be collected through a billing statement or when you present to the office for a subsequent visit or service.

We may not reduce, waive, or otherwise forgive additional amounts due. Our managed care contracts stipulate that it is our responsibility to collect the amounts due as deemed by your insurance plan coverage.

If the physician that you receive treatment from is not contracted with your insurance policy, you will be responsible for the full amount of the bill. If you provide incorrect insurance information to our office or do not update your insurance policy with our office, you will be responsible for the full amount of the bill for your visit.

If we estimate and collect more than what your insurance deems due, we will refund the overpayment to you.

If you have any questions about this statement, please direct them to the front office or clinical staff. We value you as a patient and thank you for choosing Hunt Regional Medical Partners to assist with your healthcare needs.

PATIENT ASSIGNMENT OF BENEFITS

I hereby authorize and instruct my insurance carrier to make a payment directly to **HUNT REGIONAL MEDICAL PARTNERS** benefits otherwise payable to me. I agree to personally pay for any physician charges that are not covered by or collected from any applicable insurance program, including any deductibles, coinsurance or copayment amounts. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case. I authorize Hunt Regional Medical Partners to initiate a complaint to the Insurance Commissioner if necessary for any reason on my behalf.

Patient/Guardian Signature

Date



PHYSICIAN ASSISTANT CONSENT FOR TREATMENT

The facility has on staff physician assistants 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 provider health maintenance care. Supervision does not require the constant physician presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical service provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These service may include, but not be limited to:

- Obtaining histories and performing physician examinations
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting in surgery
- Offering counseling and education
- Supply sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of a physician assistant for my health care needs. I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Patient/Guardian Signature

Date

ADVANCE PRACTICE NURSE CONSENT FOR TREATMENT

The facility has on staff advance practice nurses to assist in the delivery of medical care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above and hereby consent to the services of an advance nurse practitioner for my health care needs. I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Patient/Guardian Signature

Date



HIPAA-RELEASE OF INFORMATION

I have acknowledged/received a written copy of the "Notice of Privacy Practices" and "Patient Bill of Rights"

Patient's Name: _____ Date of Birth: _____

I hereby give permission to Hunt Regional Medical Partners and/or involved medical staff to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friends.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ Initial here if you **DO NOT** authorize assignment of any person(s) to communicate with Hunt Regional Medical Partners and/or involved medical staff for any reason.

I wish to be contacted in the following manner:

Home# _____	Cell# _____	Work# _____
Ok to leave a message?	Ok to leave a message?	Ok to leave a message?
Yes _____ No _____	Yes _____ No _____	Yes _____ No _____

You may send Correspondence to my home address? Yes _____ No _____

The duration of the authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

Patient/Representative Print Name: _____

Patient/Representative Signature: _____ Date: _____

Relationship (if other than patient): _____