Valley Internal Medicine Associates

2121 E Griffin Pkwy, Ste 10, Mission, TX-78572
Ph: 956-583-7393 Fax: 956-583-7309

PATIENT REGISTRATION AND CONSENT TO TREATMENT

PLEASE PRINT **TODAY'S DATE:** ___________________________

NAME: ____ **DOB:**____/____/____ **AGE:** ______
Last First MI

SS #_______/________/________

ADDRESS:____/________________________________/_______________/_____________
Street / PO Box City State Zip

HOME PHONE ________________________**CELL PHONE** __________________________ **WORK PHONE** _________________________

Leave message at home: ______________________ **Leave message at work:** ______________________________

Other numbers to leave message: _________________________________

Email: ____

Pharmacy of Preference:

EMPLOYER NAME____**EMPLOYER PHONE** ________________________________

EMPLOYER ADDRESS:____/________________________________/_______________/_____________
Street / PO Box City State

PRIMARY HEALTH INSURANCE *****STAFF WILL COPY ALL INSURANCE CARDS**

INSURANCE COMPANY_____________________________**SUBSCRIBER NAME** _____________________________**DOB**____/____/___

Subscriber's SS# (if different than patient) _______/_______/________ **Relationship to patient**__________________________

*****If spouse carries coverage, please list EMPLOYERS NAME**____**PHONE**__________________________

EMPLOYER ADDRESS:____/________________________________/_______________/_____________
Street / PO Box City State Zip

ID NUMBER:____________________________ **GROUP NUMBER:**______________________________ **EFFECTIVE DATE:**________/______/________

SECONDARY HEALTH INSURANCE OR MEDICARE SUPPLEMENT

INSURANCE COMPANY________________________ **SUBSCRIBER NAME**_____________________ **DOB**_____/____/_____

ID NUMBER__________________________**GROUP NUMBER**__________________**EFFECTIVE DATE**_____/______/_______

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: ____ **RELATIONSHIP:** ___________________
Last First MI

ADDRESS:____/________________________________/_______________/_____________
Street / PO Box City State Zip

HOME PHONE_________________________ **CELL PHONE**__________________________ **WORK PHONE**_____________________

Patient Name: ____ DOB: ________________________

Patient Financial Responsibility

The physicians and staff at **Valley Internal Medicine Associates** appreciate the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.
You are responsible for referrals, payment of all deductibles and co-payment/co-insurance, procedures without authorization, non covered charges as determined by your contract with your insurance carrier. All payments are due at time of service. Payment options are cash, check, Visa, MasterCard, Discover and Amex. There is a $30.00 per check fee for each time your check is returned by the bank. If your account becomes past due, Valley Internal Medicine Associates will take the necessary steps to collect the debt, including but not limited to collection agency, lawyers, and reporting to Credit Bureau where you agree to pay all of the collection costs incurred.
I have read the above policy regarding my financial responsibility to **Valley Internal Medicine Associates** for providing medical services to me or the above named patient. I certify that the information I provide to **Valley Internal Medicine Associates** is, to the best of my knowledge is current, true and accurate. I authorize my insurer to pay any benefits directly to **Valley Internal Medicine Associates,** the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Signature ____Date ___________________________

Self-Pay

I do not have health insurance and I will be responsible for all medical services rendered at **Valley Internal Medicine Associates.** I agree to pay **Valley Internal Medicine Associates** for the full amount of charges related to the office visit and any treatment/procedure rendered to me or to the above named patient at each visit.

Patient/Guarantor Signature ____ Date _____________________________

Cancellations and No-Show Policy

We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and no-shows will be billed per occurrence of cancellation/no-show. Patients will be expected to pay the cancellation/no-show fee prior to, or at the time of their next appointment.

Patient/Guarantor Initials ____________________Date ___________________________

Consent for Treatment and Authorization to Release Information

I hereby authorize **Valley Internal Medicine Associates**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize **Valley Internal Medicine Associates** to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

I further authorize **Valley Internal Medicine Associates** to contact, discuss my personal health information with:

Name: ____ Relationship____________________

Name: ____ Relationship____________________

Patient/Guarantor Signature: ______________________________Date ___________________________

Acknowledgement of Valley Internal Medicine Associates Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of Valley **Internal Medicine Associates** Notice of Privacy Practices.

Patient/Guarantor Signature: __________________________________ Date________________________