

Texas Partners In Acute Care, LP

Boerne Acute Care Center
Little Spurs Pediatric Urgent Care

Welcome!!

Registration Form

Please Print

Our Mission Is To Provide The Best Possible Care To Our Patients

How Did You Hear About Our Practice? Friend Relative Dr. _____ Yellow Pages On Line Close to Home Other _____

Patient Information

Patient Name _____ Date of Birth _____ / _____ / _____ Age _____ Sex: M F
Month Day Year YYYY
S.S. # _____ / _____ / _____ Marital Status: S M W Sep Div Home Tel #(_____) _____ Cell #(_____) _____
Work Tel #(_____) _____ Address _____ City _____ State _____ Zip _____
Mailing Address (if different) _____ City _____ State _____ Zip _____
Pediatrician/Family Doctor _____ Tel #(_____) _____ Fax#(_____) _____

Policy Holder Responsible Party Information

Name _____ Relationship to Patient _____ DOB _____ / _____ / _____ S.S.# _____ / _____ / _____
Month Day Year YYYY
Sex: M F Mailing Address _____ City _____ State _____ Zip _____
Home Tel #(_____) _____ Cell #(_____) _____ Work Tel #(_____) _____ Employer _____
Occupation _____ Employer Address _____ City _____ State _____ Zip _____

Insurance

I Do Not Have Insurance Coverage At This Time

#1 Name of Primary Insurance Co _____ Subscriber Name _____ Relationship to Pt _____
DOB _____ / _____ / _____ S.S.# _____ / _____ / _____ Employer _____ Tel No(_____) _____
Month Day Year YYYY
#2 Name of Secondary Insurance Co _____ Subscriber's Name _____ Relationship to Pt _____
DOB _____ / _____ / _____ S.S.# _____ / _____ / _____ Employer _____ Tel No(_____) _____
Month Day Year YYYY

Spouse Information

Spouse's Name _____ Employer _____ Empl Tel #(_____) _____
Employer Address _____ City _____ State _____ Zip Code _____

Emergency Contact

Contact Name _____ Relationship to Patient _____ Phone #(_____) _____ Alternate #(_____) _____
Address _____ City _____ State _____ Zip _____

Assignments of Benefits – Financial Agreement

_____ I authorize my insurance benefits be paid directly to Texas Partners In Acute Care (TPIAC).
_____ I have read, understand, and agree to the Practice (TPIAC) Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. In the event of my default, or non-payment of my bill, I agree to pay all costs of collections, reasonable attorney's fees and court costs due in addition to the amount due that may be attached.
_____ I hereby authorize Texas Partners In Acute Care and their healthcare providers to release all information necessary to my insurance company both when requested, or to facilitate the payment of my claim(s). I further agree that a photocopy of this agreement shall be as valid as the original.
_____ As the parent, guardian or custodian of the patient, I agree to be responsible for all services rendered to minor patients. I hold TPIAC harmless for attempts to collect regardless of parental, guardian or custodial financial responsibility. I agree to be responsible for payment regardless of any divorce, separation or other outside agreements that may or may not be in effect at the time of service.
_____ I hereby give my consent and authorization to TPIAC, subsidiaries and practitioners to provide my medical treatment. I understand that the physician, and/or nurse practitioner and/or physician assistant will explain my condition(s), foreseeable risks, and methods of treatment for my condition(s) before treatment is provided. I authorize TPIAC, its subsidiaries and practitioners to perform any additional or different treatment that is thought necessary, should, in an emergency situation, a condition be discovered which was not known previously. I can be reached at the telephone # listed above in case of emergency results or further care is deemed necessary.
_____ I authorize the release of my medical records, or in case of a minor, my child's medical records, to my primary care physician. This and any other subsequent authorizations to release Protected Health Information comply with the privacy practices notice and Federal HIPAA regulations. I have been provided a copy of the Notice of Privacy Practices and Patient Financial Policy.