Texas Partners In Acute Care, PLLC

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 Find Our Practice? PLEASE CIRCLE

PLEASE CIRCLE: **Friend Relative Military Yellow Pages On Line Drive By Saw Sign Newspaper Radio Work Other (Specify)**

Patient Information

Patient Name _____ Date of Birth ____/____/____ (Month/Day/Year YYYY) Age____ Sex: ☐ M ☐ F

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 toPatient_____ DOB____/____/____ (Month/Day/Year YYYY) S.S.#____/____/____

Sex: ☐M ☐F Mailing Address_____ City_____ State____ Zip_____

Home Tel #(____)_____ Cell #(____)_____ Work Tel #(____)_____ Employer_____

Occupation_____ Employer Address_____ City_____ State___ Zip_____

Please Answer: ** >> May We Leave Messages at the Numbers Indicated Above? Circle One: Yes No**

**********>> May We Leave Messages to Include Lab Results and other Medical Information at the Numbers Indicated Above? (Circle) Yes No**

Insurance: _____I Do Not Have Coverage At This Time

#1 Name of Primary Insurance Co_____ Subscriber Name_____ Relationship to Pt____

DOB____/____/____ (Month/Day/Year YYYY) S.S #____/____/____ Employer_____ Tel No(____)_____

#2 Name of Secondary Insurance Co _____ Subscriber's Name_____ Relationship to Pt____

DOB____/____/____ (Month/Day/Year YYYY) S.S #____/____/____ Employer_____ Tel No(____)_____

Spouse's Name_____ Employer_____ Empl Tel #(____)_____

Employer Address_____ City_____ State_____ Zip Code_____

Emergency Contact

Contact Name_____ Relationship to Patient_____ Phone # ( ) ____ _____ Alternate #_____

Assignments of Benefits – Financial Agreement --Please Read and Initial Each Paragraph

_____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

_____I authorize Texas Partners In Acute Care, PLLC, providers and representatives to leave messages for lab results and other possible medical information at the phone numbers provided.

_____ _____

Patient/Guardian Signature Date