

Trinity Family Medicine

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 Phone 512-258-1645 Fax 512-258-2586

PATIENT INFORMATION:

Patient's Name: <small>Last</small>			<small>First</small>			<small>Middle</small>						
Mailing Address: <small>Number</small>		<small>Street</small>		<small>Unit #</small>		<small>City</small>		<small>State</small>		<small>Zip Code</small>		
Home Telephone:				Work Telephone:				Cell Phone:				
Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number:			Driver License Number:		State:			
Employer:			Employer Address:				<small>City</small>		<small>State</small>		<small>Zip Code</small>	
Occupation:			Marital Status:									
			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other									
Spouse's Name:				Spouse's Social Security #				Spouse's Date of Birth:				
Guarantor's Name:					Guarantor's Address: (If not same as patient's address)							
Emergency Contact Name:					Work Phone:			Cell Phone:				

How Did you hear about Trinity Family Medicine?

INSURANCE INFORMATION:

Primary Insurance Company:		Policy/Subscriber ID#			Group Number:		
Whose job provides Insurance:?				Name		Telephone:	
<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other							
Secondary Insurance Company:		Policy/Subscriber ID#			Group Number:		
Whose job provides Insurance:?				Name		Telephone:	
<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other							

PATIENT CONSENT:

IF INSURED:

The undersigned hereby authorizes the release of any information regarding all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

IF NOT INSURED:

I understand that Trinity Family Medicine is accepting me as a private pay patient. I will be responsible for paying for all services that I receive from this Practice. The doctor's office will not file a claim to any insurance company, including Medicaid for services provided to me.

By signing below, I affirm that I have read and understood a copy of the Protected Health Information Policy (PHI).

Patient Signature:	Date:
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Patient Contact Sheet

It is the intent of Trinity Family Medicine to limit both **Private** and **Confidential** information to our patients only. In accordance with our Office Policies, if your results are urgent or reveal a serious illness, we will contact you by any means necessary. To accomplish this, we are requesting that each patient provide us with the following information:

Home Telephone:	Cell Phone Number:	Work Telephone:	E-mail Address:
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May this Practice leave Private or Confidential messages or information on any of the below?
 (Check as many as apply)

- Home
 Cell
 Work
 E-mail
 Regular Mail

Please provide the name(s) of person(s) who you authorized to receive urgent medical information:

Name:	Cell Phone Number:	Other Phone Number:	Relationship:
Name:	Cell Phone Number:	Other Phone Number:	Relationship:
Name:	Cell Phone Number:	Other Phone Number:	Relationship:

Please provide the name(s) of person(s) who you authorize to receive information regarding your care and who may obtain information regarding appointments and medical treatment plans:

Name:	Cell Phone Number:	Other Phone Number:	Relationship:
Name:	Cell Phone Number:	Other Phone Number:	Relationship:
Name:	Cell Phone Number:	Other Phone Number:	Relationship:

My signature below certifies that I have willfully provided this information to Trinity Family Medicine and that I fully understand and agree with the purpose and the use of the above information.

Print Patient Name:	Date
Patient or Guardian Signature:	Date

Payment Policies

Thank you for choosing Trinity Family Medicine as your primary care provider. Some of our patients have had concerns regarding insurance versus patient responsibility for payment of services rendered. Due to those concerns we have developed the following payment policies:

INSURANCE: Our Practice participates in most insurance plans. Contact your insurance company with any questions that you may have regarding your coverage. Please ensure that you have an up-to-date card when you come for your visit. **Understanding the benefits provided is the patient's responsibility.**

Non-Insured Patients: Payment in full is due when service is rendered.

Non-Covered Services: Be aware that some (or all) of the services you receive may not be covered (or deemed necessary or reasonable) by your insurance provider. Payment must be in full at the time of the visit.

Co-Payments and Deductibles: All co-payments and deductibles must be paid when service is rendered. This is an arrangement as part of the contract with the insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered as fraud.

Proof of Insurance: We must obtain a copy of your current valid insurance card. If a patient fails to provide such proof, then payment in full is due at the time of the visit.

Claims Submission: Some insurance providers may require the patient to mail in a form. This is a contract between the patient and the insurance company; therefore it is the patient's responsibility to comply. Please understand that the balance of the bill is YOUR responsibility. Trinity Family Medicine is not a party to the contract between you and your insurance company.

Coverage Changes: In the event your insurance coverage changes, you must notify the Practice before your next visit.

Nonpayment of Claims: If your insurance provider does not pay your claim in 45 days, the balance will automatically be billed to the patient. If your account is over 60 days past due, the patient will receive a letter stating that they have 10 days to pay the account in full. Partial payments will not be accepted unless negotiated. Delinquent accounts will be sent to collections and the patient terminated from the Practice.

Missed Appointments: Trinity Family Medicine, as a policy, charges for missed appointments. The charges are not billed to the insurance provider, but are the responsibility of the patient. Please keep all scheduled appointments.

By signing below, I affirm that I have read and understand the Payment Policies of Trinity Family Medicine.

Patient or Responsible Party Signature:	Date:
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