Prime Healthcare Providers

Dr. Phillip Weinstein (General Practice) ~ Dr. Adam Weinstein (Internal Medicine)
902 Frostwood, Suite 262 ~ Houston, Tx 77024
Phone: (713) 932-0118 ~ Fax (713) 932-8303

TODAYS DATE
/ /

REGISTRATION INFORMATION

PATIENT INFORMATION

PATIENT - NAME (FIRST, MIDDLE, LAST) ,	SEX
DATE OF BIRTH / /	AGE
TX DRIVERS LIC#	SOCIAL SECURITY
PATIENT - MAILING ADDRESS, (STREET & APARTMENT NUMBER or PO BOX)	
PATIENT - MAILING ADDRESS (CITY, STATE & ZIP) , ,	
PATIENT - HOME PHONE ( ) -	WORK PHONE ( ) -
CELL PHONE ( ) -	
PATIENT - MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	
OTHER:	
PATIENT - EMPLOYER'S NAME	
PATIENT - EMPLOYER'S ADDRESS / PHONE NUMBER ( ) - Ext.	
PATIENT – OCCUPATION	PATIENT – E-mail
PATIENT - PREVIOUS PHYSICIAN, ADDRESS & PHONE NUMBER ( ) - Ext.	
NAME EMERGENCY CONTACT	EMERGENCY CONTACT PHONE NUMBER ( ) - Ext.
NEAREST RELATIVE NOT LIVING WITH YOU	RELATIVE'S PHONE NUMBER ( ) - Ext.

GUARANTOR INFORMATION *(Omit if same as patient)*

GUARANTOR - NAME (FIRST, MIDDLE, LAST) ,	SEX
DATE OF BIRTH / /	AGE
TX DRIVERS LIC#	SOCIAL SECURITY
GUARANTOR – MAILING ADDRESS, (STREET & APARTMENT NUMBER or PO BOX)	
GUARANTOR - ADDRESS, (CITY, STATE & ZIP) , ,	
GUARANTOR - HOME PHONE ( ) -	WORK PHONE ( ) -
CELL PHONE ( ) -	
GUARANTOR - MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED	
GUARANTOR - RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Child ☐ Mother ☐ Father ☐ Other	
GUARANTOR - EMPLOYER NAME	
GUARANTOR - EMPLOYER ADDRESS / PHONE NUMBER ( ) - Ext.	
GUARANTOR – OCCUPATION	GUARANTOR – E-mail
SPOUSE'S EMPLOYER / WORK PHONE NUMBER ( ) - Ext.	
NEAREST FRIEND NOT LIVING WITH YOU	FRIEND'S PHONE NUMBER ( ) - Ext.
HOW WERE YOU REFERRED TO OUR PRACTICE? ☐ PATIENT ☐ FRIEND ☐ RADIO ☐ TV ☐ OTHER DOCTOR ☐ PHONE BOOK ☐ INSURANCE CO. ☐ OTHER (Please explain)	

PRIMARY - INSURANCE INFORMATION

PRIMARY INS - NAME OF POLICYHOLDER (FIRST, MIDDLE, LAST) ,	SEX
SUBSCRIBER'S DATE OF BIRTH / /	SOCIAL SECURITY NUMBER
NAME OF INSURANCE – PRIMARY PRIMARY: TYPE OF POLICY ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ STANDARD INDEMNITY)	
POLICY NUMBER/ID#	GROUP NUMBER
PRIMARY INSURANCE – BILLING ADDRESS (STREET or PO BOX)	
PRIMARY INSURANCE – BILLING ADDRESS (CITY, STATE & ZIP) , ,	
PRIMARY INSURANCE - PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.	
SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other	
SUBSCRIBER'S EMPLOYER - NAME	
EMPLOYER ADDRESS (STREET, CITY, STATE & ZIP) , , , ,	PHONE NUMBER
CURRENT PCP (AS LISTED ON CARD)	

SECONDARY - INSURANCE INFORMATION *(Omit if none)*

SECONDARY INS - NAME OF POLICYHOLDER (FIRST, MIDDLE, LAST) ,	SEX
SUBSCRIBER'S DATE OF BIRTH / /	SOCIAL SECURITY NUMBER
NAME OF INSURANCE – SECONDARY SECONDARY: TYPE OF POLICY ☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ STANDARD INDEMNITY)	
POLICY NUMBER/ID#	GROUP NUMBER
SECONDARY INSURANCE – BILLING ADDRESS (STREET or PO BOX)	
SECONDARY INSURANCE - BILLING ADDRESS (CITY, STATE & ZIP) , ,	
SECONDARY INSURANCE - PHONE NUMBER (INCLUDE AREA CODE) ( ) - Ext.	
SUBSCRIBER'S RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other	
SUBSCRIBER'S EMPLOYER - NAME	
EMPLOYER ADDRESS (STREET, CITY, STATE & ZIP) , , , ,	PHONE NUMBER
OTHER	

WILL BE PAYING TODAY WITH
☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ EXTENDED PAYMENT **(APPROVAL REQUIRED)**

I understand and agree that I am ultimately responsible for payment. I certify that this information is true and correct to the best of my knowledge.

Signature of Person Financially Responsible   Date   Accepted by

PLEASE COMPLETE THE REVERSE SIDE

Prime Healthcare Providers

Office and Financial Policies

Welcome to Prime Healthcare Providers. Thank you for choosing our office as your health care provider. We are committed to your treatment being successful and providing you with the best possible care. It is to our mutual benefit that our patients understand our "Financial Policies". Please understand that payment of your bills is considered a part of your treatment agreement.

The following is a statement of our Financial and Office Policies, which we require you to read and sign prior to treatment.

Payment in full is due at the time of service unless arrangements have been made in advance by your carrier. For your convenience, we accept cash, check, Visa, MasterCard, American Express and Discover.

Assignment of Insurance Benefits to Doctor: Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim, if you assign the benefits to the doctor - in other words, if you agree to have your insurance company, pay the doctor directly. You will also be responsible for following up with your insurance company to ensure that the claim is paid within 60 days of your visit date.

Request of Insurance Information: We expect that if your insurance company requests information from you, in order to process your claim properly, you will NOT delay and you will respond quickly so as to not cause them to delay their payment.

Deductibles, Co-Insurance & Co-Payments: If your insurance company does not pay the practice within a reasonable period (60 days), we look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you will be required to pay any **deductibles, co-insurance or co-payments at the time of your visit.** It is your responsibility to know your plan benefits and the requirements of your insurance company.

Non-Covered Services: Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Valid Insurance Information: We assume that the insurance information that you provide us is correct and by signing the acknowledgment below, you verify that it is. In the event that your insurance changes, it is your responsibility to provide the most recent and correct insurance information. Failure to keep your insurance current may lead to you being billed for the entire amount of the services. It is understood, that if your insurance claim is denied due to incorrect personal information or incorrect insurance information that you provided, you will be billed and payment in full will be due immediately.

Insurance Prior Authorizations: Many insurance plans require prior authorizations for certain tests, referrals, ER visits and/or treatment. These must be obtained PRIOR to treatment. Without prior authorization, your insurance may refuse to pay, and you will be responsible for all of the charges. It is your responsibility to obtain referrals at the time of your office visit.

No Insurance? or Out of Network?: If you do NOT have insurance, or you are insured by a company that we are NOT contracted with, we will be happy to provide treatment, however, payment in full will be required at the time of service. We will file a claim with your insurance company, and that you will be responsible for following up with your insurance company to ensure your claim is reimbursed to you. It is understood that PHP cannot act as an intermediary between you and your insurance company to effect payment.

Hospitalizations: We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

Past Due Balances: It is our policy to turn past due balances over 120 days to the credit bureau unless special arrangements have been made.

Our Fees: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any contracted insurance company's arbitrary determination of usual and customary fees.

Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for repeated missed appointments at the rate of $25.00 for missed office visits and $50.00 for missed scheduled procedures.

Returned Checks: Returned checks will be assessed a charge of $25.00 for each returned check. We will NOT resubmit checks once returned. Certified funds, or cash in the amount of the check, plus the $25,00 return fee will need to be brought into our office prior to your next appointment to allow you to be seen by the physician. Personal checks will NOT be accepted after 2 returned checks.

Authorization to Treat: By signing below, you authorize PHP to deliver medical care to yourself or to any dependents listed on the insurance form. Minors (children under 18 years of age) must be accompanied by a parent or legal guardian who must assume financial responsibility.

Lab and X-ray Results: These are usually mailed out within 10 business days following receipt of the results. If you do not hear from us by then please call the office so we can begin a search.

Prescription Refills: Prescription refills are provided to you at the time of service in quantities sufficient to last until your next office visit. Due to our safety concerns about possible medication errors and to comply with HIPAA guidelines to protect your privacy, we discourage refilling prescriptions over the phone or fax and we do not prescribe antibiotics over the phone.

Motor Vehicle Accidents: Services rendered as a result of a motor vehicle accidents are billed directly to the patient.

Workers Comp: We do not accept Workers Comp.

I Authorize the Following

- **Release of Information:** You further authorize PHP to release medical information to your insurance company concerning any illness and treatment.
- **Authorize Payment from my Insurance Company or Third Party Payor** to Phillip Weinstein, M.D., PA and/or Adam Weinstein, D.O. for services rendered to me or my dependent(s) subsequent to this date and for any and all other charges as may be incurred by this office relative to said service(s).

Consent for Use and Disclosure of Protected Health Information

With my consent, Prime Healthcare Providers PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Prime Healthcare Providers PLLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Prime Healthcare Providers PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Prime Healthcare Providers PLLC Attn: Angela Gomez / Privacy Officer @ 902 Frostwood, #262 Houston, Texas 77024. I have the right to request that Prime Healthcare Providers PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting Prime Healthcare Providers PLLC use and disclosure of my PHI to carry out TPO. You also acknowledge that PHP has provided you copies of their Privacy Notice and understand their contents. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, the doctors of Prime Healthcare Providers PLLC may decline to provide treatment to me.**

I have read and understand the practice's "Office, Privacy and Financial Policies" and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of Person Financially Responsible Date

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Please Print the Name of the Person Financially Responsible

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Witness Date