GUADALUPE FAMILY HEALTH, PA

PATIENT INFORMATION AND POLICIES

Last name: _____ First name: _____

Preferred name: _____ Date of birth: _____ Social Security #: _____

Gender: _____ Marital status: _____ Occupation and employer: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

Daytime phone: _____

Emergency contact name and/or person I give permission to release medical information to, if needed:

_____ Relationship: _____ Phone: _____

Patient or responsible party email address for access to Patient Portal: _____

Preferred pharmacy and location: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____

Organ donor: ☐ Yes ☐ No Living will: ☐ Yes ☐ No

Race:

☐ White
☐ Black
☐ Asian
☐ American Indian
☐ Native Hawaiian
☐ Other: _____

Ethnicity:

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Mexican
☐ Other: _____

PRIMARY INSURANCE: *PRESENT INSURANCE CARD(S) TO RECEPTIONIST*

Insured name: _____ DOB: _____ Relationship: _____

Secondary insurance insured name and DOB (if any): _____

May we release health information about you to family member(s) or another individual or care giver(s)? ☐ Yes ☐ No

Please list: _____

Please provide your ID and Insurance Card(s) upon check-in with receptionist* *Copays due at the time of service

***Private Pay or Uninsured Patients: Payment for services due at the time of service* Thank you.**

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that the Practice provided me or offered me a written copy of the Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient or responsible party signature	Date	Relationship if not patient

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below, I give permission to the providers of Guadalupe Family Health PA to access my pharmacy benefits data electronically through RxHub. This consent allows us to:

- Determine the pharmacy benefits and drug copays for the patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allow electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a historic list of all medications prescribed for a patient by another provider

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient or responsible party signature

1. **Permission for Treatment:** I hereby authorize the physician and/or assistants for the care of the patient named on this record to administer treatment as may be deemed necessary including examinations or treatments that may be ordered to be performed by clinical personnel. I am aware the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me to the result of examinations or treatments to be performed. I also understand that GFH employs a licensed Physician Assistant to see patients by request of the patient, or to care for sick and urgent-type appointments when my physician is not available.

   Initials _____

2. **Permission for Release of Medical Information:** I understand and agree that any of the above information may be used, if necessary, for purposes of the communication for appointment changes, accounts receivable, emergencies, etc. Information from any medical records may be released, if necessary for insurance purposes.

   Initials _____

3. **Assignment of Benefits:** I hereby authorize my insurance company(s) to make payment(s) as stipulated in my policy for any services furnished and that such payment(s) be paid directly to the provider of the services.

   Initials _____

4. **Payment for Services Rendered:** I also understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered and I agree to pay upon demand or as agreed for the related changes of remaining charges following my insurance payment(s). I agree to pay copays at the time of service. If private pay, I agree to pay for services in full on the date of service. I understand that if I am not able to pay my expected portion, I may be asked to reschedule my appointment.

   Initials _____

Copays due at the time of service. Private Pay or Uninsured Patients: Payment for services due at the time of service. Kindly give 24 hours notice for rescheduled or cancelled appointments. Multiple no show appointments may be subject to patient dismissal from the practice. Thank you.

PRESCRIPTION REFILL POLICY

- NO prescriptions will be refilled after clinic hours.
- We require 48 hours minimum to process prescription refill requests either to the pharmacy or for patient pick up.
- Non-controlled/non-narcotic prescriptions require an appointment, and possible labs, if there are no refills available at the pharmacy. **Please call the office before you run out of medication.**
- Controlled substances/narcotic prescriptions require a follow-up no less than every three months or at the discretion of the physician. Prescriptions MUST be picked up and signed for in person. We will not mail prescriptions. You may be subject to drug testing at any time – NO EXCUSES.
- New symptoms and/or dosage changes require an appointment. Providers will not diagnose or change medication via phone.
- A signed "Controlled Substance/Narcotics Policy" is required if you are prescribed narcotics or controlled medications and is strictly enforced.

By signing below, I acknowledge that I have read and understood the above policy and agree to abide by it.

_____ _____

Patient signature Date

Thank you for choosing Guadalupe Family Health PA for you and your family's healthcare.

Visit our website at www.GuadalupeFamilyHealth.com or "like" us on Facebook.