



# FAMILY PRACTICE & BAYTOWN URGENT CARE

2800 Garth Road, Baytown, TX 77521  
Tel: (281) 425-3800 Fax: (281) 425-3992

## REGISTRATION INFORMATION

### PATIENT DETAILS

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_  
 Street City State Zip  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex:  Male  Female  
 Driver License # \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Separated  Divorced  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_ Phone \_\_\_\_\_

### SPOUSE / GUARANTOR DETAILS

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_  
 Street City State Zip  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Who is responsible for this account \_\_\_\_\_ Relationship to patient \_\_\_\_\_

### INSURANCE DETAILS

Do you have medical Insurance?  Yes  No  
 If Yes, Name of Primary Insurance \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay \_\_\_\_\_  
 Name of Secondary Insurance \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Co-pay \_\_\_\_\_  
 Medicare # \_\_\_\_\_  Medicaid # \_\_\_\_\_  
 In case of Emergency, who should be notified \_\_\_\_\_  
 Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Jacinto Medical Group,  
 Name of Insurance Company  
 all medical benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
(Signature of Insured/Guardian)

\_\_\_\_\_  
DATE

#### MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jacinto Medical Group for any services furnished me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA - 1588 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination to the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
BENEFICIARY SIGNATURE

\_\_\_\_\_  
DATE



**Patient Consent and Acknowledgment Form for Use and Disclosure of Protected Health Information**

I hereby give my consent for Jacinto Medical Group, P.A. (JMG) , Jacinto Medical Corporation (JMC), and /or Baytown Urgent Care, Ltd.(BUC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided to me by JMG, JMC, and/or BUC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. JMG, JMC, and/or BUC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Cathy Rouse, Office Manager at 2800 Garth Road, Baytown, Texas or by calling (281) 425-3800** for further information.

With this consent, JMG, JMC, and/or BUC may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, JMG and/or JMC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, JMG, JMC, and/or BUC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that JMG and/or JMC restrict how it uses or discloses my PHI to carry out TPO. 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 acknowledging receipt of the Notice of Privacy Practices and consenting to allow JMG, JMC, and/or BUC to use and disclose my PHI to carry out TPO.

Furthermore, I understand that JMG, JMC, and/or BUC have an electronic medical records system, which entails all of my private healthcare information. Within this electronic system, there is a function to include a digital photograph on each patient's chart. This photograph is solely used as to identify the patient upon reviewing the patient's chart. I hereby consent to JMG, JMC, and/or BUC and his or her assistants as necessary to photograph myself as the patient on record and to download onto my electronic medical chart.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If you do not sign this consent, or later revoke it, JMG and/or JMC may decline to provide treatment to me. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Signed by: \_\_\_\_\_  
**Signature of Patient or Legal Guardian                      Date                      Relationship to Patient**

\_\_\_\_\_  
**Printed Patient's Name    Print Name of Legal Guardian, if applicable**

\_\_\_\_\_  
**Signature of JMG/JMC Authorized Representative                      Date**

**Consent to Treat**

I hereby authorize and direct JMG, JMC, and/or BUC and his or her assistants as necessary to perform quality care, to perform the following procedures/treatment upon me:

Medical Care Visits                       Procedure/Treatment: \_\_\_\_\_

The nature and purpose of this procedure, alternative methods of treatment, and potential risks and complications listed below have been fully explained to me, including the following: \_\_\_\_\_ procedure/ treatment(s) upon me.

I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of this procedure and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

**Print Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

*If the patient is a minor or has a legally designated representative:*

**Print Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Representative Signature** \_\_\_\_\_





## FAMILY PRACTICE

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### NEW PATIENT INFORMATION SHEET

#### **OFFICE VISIT POLICY**

If you are a new patient, we welcome you to Jacinto Medical Group. Our goal is to give you the most efficient and proper care. For existing patients, we thank you for your loyalty and hope we have and will continue to provide you with the best care. We ask that you arrive to every appointment at least 10 minutes ahead of time. This will allow us to get you check in and verify your insurance, if need be. We do verify insurance information for all new patients and every 6 months thereafter. Please be prepared to show your insurance card at the time of each visit.

If you are calling in to schedule an appointment, please be prepared to confirm your current address, phone #, and date of birth. They will also confirm your current insurance information. .

#### **WALK-IN CLINIC**

For your convenience, if you are in need of medical attention due to an acute problem. We do have a Physician Assistant (PA) on staff that would provide the necessary care under the supervisor of JMG physicians on site. The clinic is opened 8:00AM - 11:30AM and 2:00PM - 4:30PM. This is on a walk-in basis, so please remember, you could wait an hour or so, but we strive for quick, yet personal attention.

#### **REFILL POLICY**

If a refill is needed, please allow us 24 hours notice to obtain approval from your physician. Please have the pharmacy send the refill request Electronically via Surescripts or Fax us at 281-425-3992. Routine medication refills will be filled from 8:30AM - 3:00PM weekdays only.

#### **PATIENT MEDICAL QUESTIONS**

If you have any questions regarding your medical care, please call our office during office hours (8:00-5:00) at 281-425-3800. You will then be transferred to the appropriate nurse's phone. If voice mail picks up, leave a message and the nurse will return your call in a timely matter. If it is an emergency, please state the problem, and we will have one of our staff members deliver the message to the nurse directly. If you have an emergency after hours, weekends, or holidays, you can contact the answering service at 713-935-2339. They will then page our on call physician for your call to be returned.

#### **PATIENT ASSISTANCE PROGRAMS**

We do offer a patient assistance program in our office for the patients that qualify for financial aide in obtaining their medications. We do this through [www.needymeds.com](http://www.needymeds.com). You may also go to [www.needymeds.com](http://www.needymeds.com) for all the proper forms needed. If you are on this program and need refills, please call 3 weeks prior to your medication running out.

#### **APPOINTMENT CONFIRMATION**

We now have an electronic call system that will verify your scheduled appointment. Please listen to the message and press the appropriate button to confirm your appointment.

#### **CANCELLATIONS**

If you are unable to your appointment, please give us 24-hour notice so that we may fill that appointment time.

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**Patient Signature**

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**Date**