Live Oak Medicine

PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below.

PATIENT'S PERSONAL INFORMATION | **MARITAL STATUS:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name: _____ _____ _____
Last Name First Name Initial

Mailing Address:_____

City:_____ State: _____ ZIP Code:_____

Please list phone numbers in the order in which you wish to be contacted.

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____) _____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Driver's License Number: _____ State: _____ Expiration Date: _____/_____

Race:_____ Ethnicity:_____

PATIENT'S/RESPONSIBLE PARTY INFORMATION | **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Name: _____ _____ _____
Last Name First Name Initial

Mailing Address *(If different from above)*:_____

City:_____ State: _____ ZIP Code:_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (_____) _____

PATIENT'S INSURANCE INFORMATION | *Please present ALL insurance cards to the receptionist.*

PRIMARY Insurance Name:_____

Claims Address:_____

City:_____ St: _____ ZIP Code:_____

Name of Insured: _____ Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____ **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Number: _____Group Number: _____ Copay: $_____

SECONDARY Insurance Name:_____

Claims Address:_____

City:_____ State: _____ ZIP Code:_____

Name of Insured: _____ Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____ **Relationship to Patient:** ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Number: _____Group Number: _____ Copay: $_____

REFERRAL INFORMATION

How did you hear about us: ☐ Friend ☐ Family member ☐ Newspaper Ad ☐ Other:_____

PHARMACY INFORMATION | *In order to process your prescription request in a timely manner please provide your preferred pharmacy.*

Pharmacy Name: _____

Phone: (_____) _____ Fax: (_____) _____

EMERGENCY CONTACT | *Please list at least one emergency contact.*

Name: _____ Relationship: _____

Address:_____

City:_____ State: _____ ZIP Code:_____

Home Phone: (_____) _____Work Phone: (_____) _____Cell Phone: (_____) _____

PATIENT REGISTRATION INFORMATION

Assignment of Benefits • Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to LIVE OAK MEDICINE, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. Our office must depend on you to receive correct insurance information. If your insurance changes, it is very important that you let us know. **IF NO PAYMENT IS RECEIVED FROM INSURANCE WITHIN 60 DAYS, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT.**

_____ (*initial)*, I authorize payment of medical and surgical benefits to Live Oak Medicine.

_____ (*initial)*, I authorize the release of any medical information necessary to process my claim.

_____ (*initial)*, I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ (*initial)*, I have reviewed the Controlled Substances policy, which explains the prescribing practices of the Live Oak Medicine physicians.

VISIT CANCELLATIONS

As in any other appointment driven office, we require a minimum of 24 hours notice for cancellations. **Last minute cancellations or failure to keep scheduled appointments may result in a charge of $25 for regular appointments and $50 for extended appointments.**

ADVANCE DIRECTIVE

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on.

Do you currently have a signed advance directive? ☐ Yes ☐ No

Would like for a copy to be kept in your medical file? ☐ Yes ☐ No

I agree that a photocopy of this agreement shall be as valid as the original.

X_____ Date:_____

Signature of patient or responsible party

Live Oak Medicine
608 Gateway Central, Suite 100, Marble Falls, TX 78654 • 3947 HWY 1431 W, Kingsland, TX 78639
830.693.2005 (phone) • 830.798.2006 (fax)

Medical Records Request

Requested From: Dr._____

Specialty: _____

City: _____ State:_____ Zip Code:_____

Phone: (_____) _____ Fax: (_____) _____

By signing this form, I authorize the release of confidential health information about me, by sending a copy of my medical records, or by a summary/narrative of my protected health information, to Live Oak Medicine.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: (_____) _____

REQUESTED RECORDS

- ☐ Discharge Records
- ☐ History and Physical
- ☐ Consult Reports
- ☐ Operative Reports
- ☐ Cardiac Reports
- ☐ Last EKG
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Pathology Reports
- ☐ Diagnostic Reports
- ☐ Other: _____
- ☐ Records from 8/2005 to present

☐ **ALL MEDICAL RECORDS**

*X*_____ _____

Signature of patient or patient's representative *Date*

_____ _____

Printed name of patient's representative *Relationship*

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____

Credit Card Payment Authorization

For your convenience, Live Oak Medicine, offers you the option to keep a credit card on file for payment of small balances or co-payments required on your account. **This information will be kept confidential and is only an option and not required.**

If you would like to participate in this option please fill out the credit card information required below. You may opt out of this credit card option at any time by contacting our office.

By signing below, I authorize Live Oak Medicine to utilize my credit card information to pay towards my co-payments, co-insurance percentages, and/or deductibles. This authorization is valid for as long as I am a patient of Live Oak Medicine. I authorize amounts of $50.00 or less to be deducted from my credit card file. Any amounts due over $50.00 will necessitate a call to me prior to the utilization of the card.

Please check the credit card name below (we do not accept American Express or Discover):

☐ Visa ☐ MasterCard

_____
Full Credit Card Number

_____
Expiration Date

_____
Printed Name of Authorized Card Holder

_____
Signature of Authorized Card Holder

_____
Mailing Address for Credit Card