

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex F \_\_\_ M \_\_\_ Marital Status: S \_ M\_ D\_ W\_ O\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_

**POLICY HOLDER INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_

I understand that I am financially responsible for any outstanding balance and or not covered service by insurance. I also authorize Bradley Axline, MD to release any information required to process claims.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Privacy Practice Acknowledgement**

I have received and/ or reviewed the Notice of Privacy Practice; I understand a copy will be provided to me upon request.

**Patient Record of Disclosures**

I authorize Bradley Axline, MD to share my protected health information with the individual(s) below:

This would include any medical information and/ or any financial billing information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I wish to be contacted in the following matter:**

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

⧠ Ok to leave message with detailed information

⧠ Leave message with call back number ONLY

**Written Communication (test results/billing information)**

⧠ Ok to mail to home address (different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Electronic Communication**

⧠ Ok to email me at my personal email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Payment Policy**

**Insured**: All patients for Dr. Axline are to pay their co-pay at time of service. If you’re unable to do so your appointment will be rescheduled. Our billing will submit claims to your commercial insurance companies, Medicare, and Medicaid. We do not participate with **Affordable Care Act**. If patient has an unmet deductible we will collect the contracted rate at time of service and invoice patient any remaining balance after claim is processed by insurance carrier. If unable to pay the contracted rate at time of service your appointment will be rescheduled. If insurance carrier pays more than anticipated refunds will be issued for any credit balances.

**Self-pay**: All patients for Dr. Axline will have to pay the amount for visit at time of service. If you come in for an initial visit and don’t have insurance but then apply for Medicaid we will collect the amount for service and will not refund you the amount.

**Collection Policy**: All patients for Dr. Axline will receive monthly statements for any unpaid balances. Accounts past due more than 30 day will receive a series of collection letters and phone calls. If payment has not been received or a payment plan established by the Final Notice is sent to accounts will be turned over to an outside collection agency and will be reported to a national credit reporting services. This information will be retained and the individual’s credit record for a period of seven (7) years.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Guarantor Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Patient/Guarantor Name Guarantor relation to patient

**Patient Authorization form**

Dr. Axline M.D. will routinely conduct urine toxicology tests on all new and established patients, during each trimester of pregnant patients, and on patients that are prescribed certain medications.

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own; it is fresh and has not n=been adulterated in any manner. I certify that the information provided on this forma and on the specimen bottle is accurate. I further authorize the laboratory to release the results of this testing to the ordering facility and or my insurance company. Furthermore, I authorize my insurance benefits directly to a US Health group affiliate lab for the service I receive. I acknowledge that the Lab & Clinic may be an out-of-network facility within my insurance. I am also aware that in some circumstances my insurance will send the payment directly to me for the services provided.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPPA NOTICE OF PRIVACY PRACTICE**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**OUR OBLIGATION**

We are required by law to:

Maintain the privacy of protected health information (PHI)

Give you this notice of our legal duties and privacy practices regarding health information about you

Follow the terms of our notice that is currently in effect

PHI includes information that we create or receive about your past, present, or future health condition, the provision of health care to you, or the payment for health care provided to you. In general, we may not use or share anymore PHI than is necessary to accomplish our purpose.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION**

Described as follows are the way we may use and disclose health information that identifies you. Except for the following purposes, we will use and disclose Health Information only with you written permission. You may revoke such permission at any time by writing to our Practice Administrator.

**Treatment:** We may use and disclose PHI for you treatment and to provide you with treatment-related healthcare services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside the office, who are involved in your medical care and need the information to provide you with medical are.

**Payment:** we may use and disclose PHI in order to bill and collect payment for the treatment and services provided to you. We may also share PHI with billing companies and companies that process our health care claims.

**Health Care Options:** We may use and disclose PHI for health care operation purposes. These uses and disclosure are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may also share information with our accountants, attorneys and others in order to make sure we are complying with the laws that affect us.

You have the following rights regarding health information we have about you:

**Your right to request limits on our use of PHI:** You may ask that we limit how we use and share your PHI. We will consider your request but are not legally required to agree to it. If we agree to your request, we will follow your limits, except in emergency situation. You cannot limit the uses and reports that we legally required or allowed to make. To request a restriction, you must make your request in writing to the Practice Administrator.

**Right to Request Confidential Communication**: You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to the Practice Administrator. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Your right to review and get a copy of PHI:** you may view or obtain a copy of your PHI. Your request must be in writing. We will reply to you within 30 days of your request. If you request a copy of your PHI, we may charge a fee. Instead of providing the PHI you requested, we may offer to give you a summary or explanation of the PHI, as long as you agree to that and to the cost advance.

**Your rights to a list of the reports we have made:** You have the right to get a list of the parties to whom we have reported your PHI. The list will not include reports for treatment, payments, or health care operation; reports you have previously authorized: reports made directly to you or your family; reports mad for national security purposes; reports to corrections or law enforcement personnel.

**We will respond to your request within 60 days:** We will include the reports made in the last six years unless you request a shorter time. The list will include the date of each report, the identity of the person (s) receiving the report, the type of information reported, and the reason for the report.

**You’re right to correct or update your PHI:** If you feel that there is mistake in your PHI, or that important information is missing, you may request a correction.

**I have received and understood Notice of Privacy Practice:**

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**Print Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Relation**

2560 Central Park Ave #340

Flower Mound, TX 75028

Phone: (972) 538-2100

Fax: (972) 539-2231