Jason N. Peet, MD
Amy Taylor, NP

PATIENT REGISTRATION INFORMATION

NAME:	DOB:
ADDRESS:	SOCIAL SECURITY:
CITY:	SEX:
STATE: ZIP:	MARITAL STATUS:
PHARMACY:	EMPLOYER:
PRIMARY PHONE:	EMERGENCY CONTACT:
SECONDARY PHONE:	EMERGENCY CONTACT PHONE:
WORK PHONE:	EMERGENCY CONTACT RELATION:

GUARANTOR INFORMATION

NAME:	DOB:
ADDRESS:	SOCIAL SECURITY:
CITY:	EMPLOYER:
STATE: ZIP:	EMPLOYER PHONE:
PRIMARY PHONE:	SECONDARY PHONE:

INSURANCE INFORMATION (THIS INCLUDES YOU MEDICARE)

PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER ID #:	SUBSCRIBER ID #:
GROUP #:	GROUP #:
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:

I confirm that the above information is correct.

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Jason N. Peet, MD and all other providers employed by this clinic, when the clinic accepts assignment.
Authorization to Release Medical Information: I hereby authorize my Provider, Jason N. Peet, MD to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent of minor) Date

New Patient Information

Name: _____ Date of Birth: _____

Please List Any Medications, including the dose and frequency (please include vitamins/supplements)

_____ _____

_____ _____

_____ _____

Please List any Allergies to Medications: _____

Please List Any Medical Problems/Diagnoses:

_____

_____

Please List Any Surgeries, and the year performed:

_____

_____

Family History: Please list any Health Issues in your family

Mother: Alive / Deceased _____ Father: Alive / Deceased _____

Social History: _____

Tobacco Use? Yes / No If yes, how much per day? _____ For how many years? _____

Alcohol Use? Yes / No If yes, how many drinks per week? _____

Any Past or Present drug use? Yes / No If yes, what kind and how much? _____

Marital Status: _____ Children: How many? _____ Education Level: _____

Job Status: _____ Occupation: _____

Health Maintenance: Have you had any of the following? Year?

Colonoscopy Yes/No _____ Shingles Vaccine Yes/No _____ Flu Vaccine Yes/No _____

Tetanus Yes/No _____ Mammogram Yes/No _____ PSA Level Yes/No _____

Pap Screen Yes/No _____ Pneumovax Vaccine Yes/No _____ Bone Density Yes / No _____

Previous Primary Care Physician:

_____

Dr. Jason N. Peet, M.D., P. A.

Jason N Peet, M.D.

Amy Taylor, NP

110 E. Live Oak

Fredericksburg, TX 78624

(830) 997-5559

BILLING NOTIFICATION TO PATIENTS

[Please Read This "Patient Waiver Form" Carefully and *SIGN* All Applicable Sections, *Prior to* Delivery of Health Care Services]

Payment at the Time of Service Policy

We file insurance as a courtesy to our patients. Until we can obtain a document from a patient's insurer to verify eligibility (EOB) under the applicable health plan (as it may or may not apply to any of this clinic's PPO contractual arrangements), we consider all professional services the responsibility of the patient. **At the time of service, all patients are responsible for co-pays, deductibles, and coinsurance**. If a patient's insurer determines that a specific health care service/visit/procedure is not covered under the applicable benefit plan, **all patients are also responsible for non-covered services at 100% of billed charges** (no PPO discount), and must pay for such at the time of service (or a billing statement will follow, Due Upon Receipt).

Financial Responsibility Agreement

I understand and agree that I am responsible for any and all charges as outlined above and will pay for such charges at the time healthcare services are rendered and/or upon receipt of a billing statement.

Signature Print Name Date

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Dr. Jason N. Peet, M.D.,PA. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize my insurance company to pay and hereby assign directly to Dr. Jason N. Peet, M.D.,P.A. all benefits, if any. If payment is made to me by my insurance company I will promptly turn payment over to Dr. Jason N. Peet, M.D.,P.A. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dr. Jason N. Peet, M.D.,P.A. will be credited to my account, in accordance with this assignment.

Signature Print Name Date

Medicare Advantage Plans Authorization (or see ABN form)

I request that payment of authorized Medicare benefits be made to Dr. Jason N. Peet, M.D.,P.A. for any health care services provided to me. I authorize any and all health care professional(s) and/or facility(s) to release any of my medical information needed to determine these benefits or the benefits payable for related services to CMS and/or its agents. 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 the ITEM 9 box of the CMS-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer, payor or agency shown. If Medicare assignment applies, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. If Medicare Advantage PFFS or PPO plan applies, **the patient is responsible for patient co-pays, coinsurance, deductibles (PPO out-of-network) and/or non-covered services, per applicable Medicare Advantage benefit plan [co-pay, coinsurance and deductibles are based upon the charge determination of the Medicare Advantage Plan Payer]**.

Signature Print Name Date

Dr. Jason N. Peet, M.D.,P.A.
110 East Live Oak
Fredericksburg, TX 78624
(830) 997-5559

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:
Full Name: _____
Other Name(s) Used: _____ Date of Birth: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Email (*Optional*): _____

Information regarding health care provider or health care entity authorized to disclose this information:
Name: _____
Address:_____City:_____ State:_____ Zip Code:_____
Phone: (_____)_____ Fax: (_____)_____

Information regarding person or entity who can receive and use this information:
Name: Dr. Jason N. Peet, M.D.,P.A.
Address: 110 East Live Oak
Fredericksburg, TX 78624
Phone: (830) 997-5559 Fax: (830) 997-5558

Specific information to be disclosed:
□ Medical Record from the last 3 years.
□ Entire Medical Record.
□ Other: _____

Include: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records
_____ Mental Health Records (Except Psychotherapy Notes)
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

Reason for release of information:
(Choose all that Apply)
□ Treatment/Continuing Medical Care
□ Personal Use
□ Billing or Claims
□ Insurance
□ Legal Purposes
□ Disability Determination
□ School
□ Employment
□ Other *(Specify)*: _____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____ Date: _____