HealthCore Physicians Group
8210 Walnut Hill • Suite 230 • Dallas, Texas 75231

PATIENT INFORMATION

Patient Registration Information

Name: _____
First MI Last

Home Phone: (_____) _____ Work: (_____) _____

Cell: (_____) _____ E-mail: _____

Address: _____
Street Apt. City State Zip

DOB: _____/_____/_____ Age: _____ Sex: _____ Social Security #: _____

Driver's License #: _____ Reason for Visit: _____

Emergency Contact: _____ Relationship: _____Phone: (_____)_____

Pharmacy Name: _____Pharmacy Phone:(_____)_____

Are you employed? _____ Yes ____ No ____ Full-Time ____ Part-Time ____ Self-Employed ____ Retired

Are you a student? _____ Yes ____ No ____ Full-Time ____ Part-Time

Marital Status: _____ Single ____ Married ____ Divorced ____ Widowed

Is the patient: _____ a minor child* ____ an adult dependent* *If you checked either, please see the receptionist for additional information.

Communication Preferences

You have the right to request that HealthCore communicate with you by alternative means or at alternate locations. Please complete the information below to tell us how you prefer to communicate with us.

I request that my medical and/or billing information be communicated to me by the following means or at the following locations (check all that apply):

___ You may contact me at my **Home / Work / Cell** (circle all that apply)
___ You may leave a message with medical information on voicemail/answering machine at my **Home / Cell** (circle all that apply)
___ Email information using my HealthCore Patient Portal account

I also request to receive reminders and notifications from HealthCore by the following means:

Appointment reminders:	___ Voice	___ Text/SMS
Health maintenance:	___ Voice	___ Text/SMS
Rx confirmations:	___ Voice	___ Text/SMS
Lab Results:	___ Voice	___ Text/SMS
General notifications:	___ Voice	___ Text/SMS

My preferred number for **VOICE** reminders and notifications is: **Home / Work / Cell** (please circle only one)

Primary Insurance Information

Primary Insurance Company: _____

_____
Primary Insured Name Insured's DOB Insured's SS # Relationship to Patient

Employer: _____

Accident Information

Is this illness/injury the result of an accident? ____ Yes ____ No If yes, please see the receptionist.

Where did it occur? ____ Work ____ Auto ____ Other Date of accident _____

Have you reported the illness/injury to your employer? ____ Yes ____ No

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Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appointment of Authorized Representative

****Please read and initial each paragraph****

_____ ***HealthCore Physicians Group*** and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to ***HealthCore Physicians Group*** for any services furnished to me by any healthcare providers associated with this group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____ I appoint ***HealthCore Physicians Group*** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ Unless I request to the contrary, in writing, I will receive appointment reminders on the answering system of any phone number I have provided on this registration form and/or via e-mail and/or appointment reminder cards sent by mail.

_____ I acknowledge receipt of the **HealthCore Policies and Informational Guide** which includes information on fees associated with no-shows, same-day cancellations and failed appointment as well as other subjects including: appointments, test results, telephone calls, refill requests, records requests, insurance, referrals, payment for services and emergencies.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and ask questions.

We understand that your health coverage is provided through _____
(Insurance Company)

- If you have out of network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, please send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
  1) This is a pre-existing illness that is not covered by your plan
  2) You may not have met your full calendar year deductible
  3) The type of medical service required is not covered by your plan
  4) The health plan was not in effect at the time of service
  5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitation in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are tying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
HealthCore Physicians Group

I have completed this form with accurate information. I have read and understand my obligation and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered by my insurance carrier.

_____ _____
Signature of Patient or Authorized Representative Date