193 Interstate Hwy 45 S, Suite H
Huntsville, TX 77340
Main: 936-570-2626 Fax: 936-463-6504

Please circle:
New Patient or
Established Patient

REGISTRATION FORM

PATIENT INFORMATION		
Last Name:	**Name:**	Marital Status:
Birth Date:	Age:	Gender at Birth:
Mailing Address: Street, Suite/Apt#, City, State, Zip:		
Social Security no.:	Home phone no.: OK to contact? Yes or No Voice-mail ok? Yes or No	**Cell phone no.:** **OK to contact? Yes or No** **Voice-mail ok? Yes or No**
Email:		
Preferred Pharmacy: Name and Zipcode	**Insurance Policy Holder Info: First Name, Last Name and Date of Birth**	
IN CASE OF EMERGENCY		
Name:	**Relationship to patient:**	**Home Phone:** Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. **I understand that I am financially responsible for any balance.** I authorize Texpress Urgent Care or insurance/collections/billing company to release any information required to process my claims. Electronic Prescribing: This office is required to use an electronic prescription system which allows prescriptions and related information to be electronically sent between the providers and your pharmacy on file. I have been made aware and understand that my provider is using electronic prescribing system and will be able to see my information medication I am already taking, including those prescribed by other providers. I give my consent to use electronic prescribing on my behalf and to see this protected health information.

Patient or Parent/Guardian signature Date

193 IH 45 S, Suite H
Huntsville, TX 77340-8570
Phone: 936-570-2626fax: 936-436-6504
https://texpressurgentcare.com

To familiarize you with the financial policy of our office, we would like to explain how your health insurance or cash pay option will be handled.

I understand Texpress Urgent Care will copy my insurance card and driver's license. Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance coverage if proper information is received. At the time of your visit, you are required to pay your co-payments, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by your insurance company. For unpaid claims over 90 days, it is your responsibility to follow up with your insurance carrier and the balance on your account is considered your responsibility. It is your responsibility to notify our front desk staff of any insurance or address changes. You will be responsible for any charges that occur if we are not notified of any insurance or address changes. Any cost incurred to collect a debt will be at the expense of the patient/responsible party. Any services that are not covered by your insurance will be your responsibility.

Acknowledgment of Financial Policy

• I understand Texpress Urgent Care will obtain demographic information including mailing address, contact phone numbers, and email address. I further understand it is my responsibility to notify Texpress Urgent Care if any demographic information changes.

_____(initial) **I understand if I do not have insurance coverage I will be responsible for services rendered at the time of service.**

• I understand Texpress **does not** accept Worker's Comp.

• I understand Texpress **does not** accept Medicaid.

• I understand Texpress is **not** in-network with United Health Care. If I am a United Health Care recipient, I understand I will be responsible for non-covered services and any charges UHC states I am responsible for.

• I understand payment for co-payments, deductibles, and percentages not covered by my insurance carrier are due at the time services are rendered.

• **Because the office handles many kinds of insurance, we may not have all the details of your insurance benefits. Some of your questions can be best answered by a representative of your insurance company.**

_____(initial) **Your insurance coverage will be verified, and your co-pay will be determined.**
All co-pays are expected at the time of service and must be paid prior to insurance being submitted.

• **If I am a Medicare recipient,** I understand I will be responsible for annual deductibles, 20% coinsurance, non-covered services, and any charges Medicare states I am responsible for.

I hereby authorize Texpress Urgent Care to furnish my insurance company with all the information which the insurance company may request concerning my present illness or injury. I hereby assign Texpress Urgent Care all money to which I am entitled for medical expenses related to the service reported. **I understand I am financially responsible to Texpress Urgent Care for charges not covered by my insurance company. I understand I am financially responsible to Texpress Urgent Care for all charges upfront if I have no insurance and am a private pay patient.**

Patient Name: _____ Patient DOB: _____

Responsible Party (if patient is under the age of 18 yrs old): _____

Responsible Party Signature: _____

Date: _____

Patient Receipt of HIPAA Privacy

Dear Patient,

Texpress Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations.

The federal privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA) have taken effect April 14, 2003. In support of our policy of complying with all applicable regulations, Texpress Urgent Care provides patients with HIPAA Notice of Privacy Rights.

While not required to receive treatment at Texpress Urgent Care, we are obligated under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you.

Thank you,

Texpress Urgent Care.

Receipt of HIPAA Privacy Notice

I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Texpress Urgent Care may use and disclose my protected health information. I understand that Texpress Urgent Care reserves that right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____

Printed Name Date

_____

Signature of Patient or Parent/Guardian

Office Use Only: To be completed only when a patient REFUSES to sign acknowledgement.

☐ Check here if patient declined/refused to sign acknowledgement

_____ _____

Staff Signature Date

Refusal to sign acknowledgement DOES NOT PREVENT the patient from continuing to be treated.

Insurance:_____

HEALTH HISTORY AND CONSENT FORM

NAME: (Last, First, Middle)_____**Birth Date:**_____
Primary Care Doctor:_____Specialist Doctor:_____
Reason for visit today?_____

Do You:

1. Do you smoke or vape?_____ If yes, how much?_____ How many years?_____
   a. If quit, when?_____
2. Do you drink alcohol?_____ If yes, how much? _____
   a. If quit, when?_____
3. Do you use any recreational/street drugs? If yes, what kind?_____
4. Any recent travel? If yes where?_____
5. Occupation: Current_____Past Occupations (if applicable)_____
6. **[Females ONLY]** Last Menstrual Period_____Hysterectomy_____ Menopause _____
7. **[Pediatrics ONLY]** Are childhood vaccines up to date? (circle one) Yes or No

List **ALL Medications** you take or are supposed to take and what they are for (Including vitamins and Birth Control):_____
_____
_____
_____

Immunizations Month/Year:
Tetanus (TD):_____
Pneumonia:_____
Flu:_____
COVID-19:_____

List **ALL Drug Allergies**:_____
_____

Previous **Surgeries** and Hospitalizations: _____
_____

Current and Past Illnesses: (check each item Yes or No; If yes, write "C" if the problem still exists)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Arthritis/Pain			High B.P			Kidney Disease			Aortic Disease		
Anemia			Heart disease			Kidney Stones			Migraines		
Bleeding disorder			Stroke/TIA			Diabetes			Pneumonia		
Allergies/Hay fever			Epilepsy/Seizure			Thyroid Disease			Anxiety		
Asthma			Liver Disease			Depression			Reflux/Ulcer		
Emphysema/COPD			High Cholesterol			DVT/PE			Cancer of		

Other Illnesses or Injuries not listed above:_____

FAMILY HISTORY: Among your MOTHER/FATHER/SISTER/BROTHER, does anyone have/had the following? (check appropriate boxes)

Family History of:	Yes	No	If yes, who has/had it?	Family History of:	Yes	No	If yes, who has/had it?
Asthma				Aortic Disease			
Diabetes				Sudden Cardiac Death			
High Blood Pressure				High Cholesterol			
Heart Attack				Breast Cancer			
Heart Disease (other)				Colon Cancer			
Stroke/TIA				Other Cancers			
Seizures/Epilepsy				Other			

CONSENT: I hereby authorize Texpress Urgent Care & its provider(s) to perform the necessary exams/procedures for the health assessment and treatment of myself and/or my children, and to furnish the resulting health information to appropriate parties like my primary care provider and/or specialist provider listed above, pharmacy and the Texas Department of State Health Services.

Signature:_____**Relationship to Patient:**_____**Date:**____/___/_____