



10310 W Grand Pkwy S
 Suite 103
 Richmond, Texas 77406
 Phone: 832-446-9444 | Fax: 832-482-1700
 Monday-Friday 9:00AM-4:00PM
 Saturday: 10:00AM-1:00PM

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME		LAST NAME		DATE OF BIRTH ____/____/____
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS	
ADDRESS				
CITY			STATE	ZIP CODE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	SPOUSES NAME		SPOUSE PHONE NUMBER	
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER		

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRIMARY CARD HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE. <input type="checkbox"/> PARENT. <input type="checkbox"/> OTHER _____	GUARANTOR'S NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	RELATION TO PATIENT
DO YOU HAVE SECONDARY INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	SECONDARY CARD HOLDER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE. <input type="checkbox"/> PARENT. <input type="checkbox"/> OTHER _____	GUARANTOR'S DATE OF BIRTH
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	PHONE #/ADDRESS

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- I also understand that I will receive a single payment receipt, if with that receipt I cannot receive reimbursement from my insurance, it is my responsibility and not Fusion Primary Care and Wellness, just as it will be my sole responsibility if the medications prescribed here are not covered by my insurance.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER
<ul style="list-style-type: none"> Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied. 	
PATIENT SIGNATURE	DATE

HIPAA Compliance Patient Consent Form

This form is designed to ensure that you understand the nature and extent of the information that we collect and use, and to give you an opportunity to authorize us to use and disclose your information for the purposes and in the manner described in this form.

We are required by law to maintain the privacy of your information and to disclose your information only to those who need to know it in order to provide you with the care you need. We will not disclose your information to anyone else without your authorization.

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____ (PRINTNAME)

Signature: _____ Date: _____

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Fusion Primary Care and Wellness assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Fusion Primary Care and Wellness for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Fusion Primary Care and Wellness is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Fusion Primary Care and Wellness is not involved. In order for Fusion Primary Care and Wellness to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Fusion Primary Care and Wellness will need to verify my health insurance coverage. In the event that Fusion Primary Care and Wellness is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Fusion Primary Care and Wellness for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Fusion Primary Care and Wellness to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Fusion Primary Care and Wellness charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Fusion Primary Care and Wellness to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Fusion Primary Care and Wellness any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Fusion Primary Care and Wellness to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize Fusion Primary Care and Wellness to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Fusion Primary Care and Wellness. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Fusion Primary Care and Wellness at (832)446-9444

In House Pharmacy: I understand that, for my convenience, Fusion Primary Care and Wellness can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

Personal Valuables: Fusion Primary Care and Wellness shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.

Fusion Primary Care and Wellness, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: _____ Date: _____



**Fusion Primary Care and Wellness
Authorization to Release Medical Records**

Name of Patient: _____

Date(s) of Service: _____

Date of Birth: _____

Social Security Number: _____

I, the undersigned, authorize to release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care
Insurance
Legal Purposes

Military
Personal Use
School

Social Security/Disability
Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical
Operative Report(s)
Lab/Pathology Report(s)

Consultation Report(s)
Discharge/Death Summary
X-Ray Report(s)/Images

Emergency Room Record(s)
Face Sheet
Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address)

TO:

(832) 446-9444/ (832) 482-1700

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone Number / Fax Number

10310 W Grand Pwky S Suite 103, Richmond, Texas 77406

Address (Street, City, State and Zip)

FROM:

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone Number / Fax Number

Address (Street, City, State and Zip)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of signature unless I revoke the authorization prior to that date.

Date: _____

Signature: _____

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

Relation to Patient