AUSTIN REGIONAL CLINIC

PATIENT DEMOGRAPHICS AND INSURANCE

Patient Label	**First Name** (Nombre)	**Last Name** (Apellido)
	Address, City, State, Zip (Dirección)	

Home phone (Teléfono de casa)	**Work phone** (Teléfono del trabajo)	**Mobile phone** (Teléfono móvil)
Date of Birth (Fecha de nacimiento)	**Sex** (Sexo)	**Marital Status** (estado civil) ☐ Single (soltera) ☐ Married (casada) ☐ Divorced (divorciada) ☐ Widowed (viuda)

E-mail	**Primary Care Doctor/Provider** (Médico):	**Phone #** (Número de teléfono):

How did you hear about the physician you are seeing today? (¿Cómo se enteró del médico que está viendo hoy?)

☐ Digital/Web Advertising ☐ Friend or Family Member ☐ Mailer/Postcard ☐ Radio Commercial ☐ Billboard
☐ News Story/Broadcast ☐ Newspaper/Magazine Ad ☐ Physician Referral ☐ Community Event/Health Fair ☐ TV Commercial

Complete this section only if the patient above is a minor

Responsible Party Last Name (Apellido de la parte responsable)	**First Name** (Nombre)
Address, City, State, Zip (Dirección)	

Home phone (Teléfono de casa)	**Work phone** (Teléfono del trabajo)	**Mobile phone** (Teléfono móvil)
E-mail (Dirección de correo electrónico):		**Marital Status** (estado civil) ☐ Single (soltera) ☐ Married (casada) ☐ Divorced (divorciada) ☐ Widowed (viuda)

Primary Insurance Company (Compañía de seguros primaria)	**Effective Date** (Fecha efectiva)
Policy ID # (ID del Paciente)	**Group ID #** (ID del Grupo)
Claims Mailing Address - Street or Box, City, State, Zip (Dirección postal de reclamos)	
Subscriber Name -policy holder (Nombre del suscriptor - titular de la póliza)	**Date of Birth** (Fecha de nacimiento)
Relationship to Patient (Relación con el paciente)	**Work Phone #** (Teléfono del trabajo #)

Subscriber Employer (Empleador suscriptor)	**Subscriber Employer Address** - Street or Box, City, State, Zip (Dirección del empleador del suscriptor)

Secondary Insurance Company (Compañía de seguros secundaria)	**Effective Date** (Fecha efectiva)
Policy ID # (ID del Paciente)	**Group ID #** (ID del Grupo)
Claims Mailing Address - Street or Box, City, State, Zip (Dirección postal de reclamos)	
Subscriber Name -policy holder (Nombre del suscriptor - titular de la póliza)	**Date of Birth** (Fecha de nacimiento)
Relationship to Patient (Relación con el paciente)	**Work Phone #** (Teléfono del trabajo #)

Subscriber Employer (Empleador suscriptor)	**Subscriber Employer Address** - Street or Box, City, State, Zip (Dirección del empleador del suscriptor)

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PATIENT REGISTRATION ACKNOWLEDGEMENT FORM

Patient Label

Direct Payment Request and Authorization to Release Medical Information

"I hereby authorize the release of information acquired during the course of my examination and treatment to the Centers for Medicare and Medicaid Services and its agents, or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare benefits directly to my physician. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I acknowledge that some ARC physicians have a financial ownership interest in area Facilities. I understand that I have a right to request and receive a copy of this disclosure of financial ownership interest. I agree that this authorization shall be valid until canceled in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. As stated in the Notice of Privacy Practice, I understand that my clinical information may be released electronically to other parties for treatment, payment, and healthcare operations. I have read the above and fully understand the terms."

Consent for Telephone Consumer Protection Act

"I acknowledge and agree that Austin Regional Clinic and any affiliates or vendor thereof, including those that assist us in collecting patient payments, may contact me by telephone or text message to any telephonic number I have provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as a dialing service or prerecorded message. I also agree to notify Austin Regional Clinic of any phone number change and if I have given up ownership or control of any such telephone number."

I understand that I am responsible for the privacy of the information that is sent to me via text and if I do not secure my device then anyone who has access to my text device will know that the message is from Austin Regional Clinic and will be able to view the content of that text. In addition, I understand the text communication may contain some or all of the following information:

- My name, ARC clinic name, location, phone number
- Type of appointment, provider or clinician name, date and time of appointment
- Link to direct me to a web site or to respond to a survey”

Patient’s Signature _____ Date _____

Responsible Party Signature _____ Date _____