KEVIN B. BROWNE, M.D.

* COMPLETE IN FULL *

* PLEASE PRINT LEGIBLY *

PATIENT NAME _____ DOB ____/____/____
Last First MI

SEX: F M AGE _____ MARITAL STATUS _____ PATIENT SS # ___ ___ _____

Student: ☐Yes ☐No ☐Full-time ☐Part-time ☐Drivers License _____ State _____ ☐Pharmacy # _____

Religion _____ E-mail Address _____

PATIENT INFO

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME #(_____) _____ WORK #(_____) _____ EXT. _____
☐ Metro ☐ Long Distance ☐ Metro ☐ Long Distance

Name (if not you) _____
Pt Spouse Mom Dad Other

CELL #(_____) _____ WORK #(_____) _____ EXT. _____
☐ Metro ☐ Long Distance ☐ Metro ☐ Long Distance

Name (if not you) _____ Name (if not you) _____
Pt Spouse Mom Dad Other Pt Spouse Mom Dad Other

PATIENT EMPLOYER NAME (if applicable) _____ RETIRED? YES NO

*PERSON RESPONSIBLE FOR BILL: SELF MOTHER / FATHER OTHER (*Adult presenting minor is responsible for bill.)

If OTHER, List Name, Address, Phone _____

MEDICAL HISTORY

Primary Care Physician _____

Address _____ Phone # _____ Fax # _____

REASON FOR VISIT _____

ALLERGIC TO ANY MEDICATIONS? YES NO

If YES, list: _____ _____ _____

_____ _____ _____

_____ _____ _____

LIST CURRENT MEDICATIONS PRESENTLY TAKING

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SMOKER? YES NO ALCOHOL? YES NO

CONTINUE ON REVERSE SIDE. → →

INSURANCE POLICY INFORMATION

* COPAY IS DUE FOR EACH OFFICE VISIT AT CHECK-IN *

(MEDICAID PATIENTS: Current month's eligibility card required for each office visit.)

PRIMARY INSURANCE- All info is REQUIRED for claim filing

CIRCLE TYPE OF PLAN: PPO HMO Referral required? Yes No

INS NAME _____

COVERAGE IS UNDER: Self Husband Wife Father Mother Other _____

Policy Holder: _____

Mailing Address _____ City _____ State _____ Zip _____
(If different from patient)

DOB of Insured (if not yourself): _____/_____/_____ Social Security # (if not yourself): _____ – _____ – _____

Insurance ID #: _____ Group #: _____

SECONDARY INSURANCE- All info is REQUIRED for claim filing

CIRCLE TYPE OF PLAN: PPO HMO Referral required? Yes No

INS NAME _____

COVERAGE IS UNDER: Self Husband Wife Father Mother Other _____

Policy Holder: _____

Mailing Address _____ City _____ State _____ Zip _____
(If different from patient)

DOB of Insured (if not yourself): _____/_____/_____ Social Security # (if not yourself): _____ – _____ – _____

Insurance ID #: _____ Group #: _____

THIRD INSURANCE- All info is REQUIRED for claim filing

CIRCLE TYPE OF PLAN: PPO HMO Referral required? Yes No

INS NAME _____

COVERAGE IS UNDER: Self Husband Wife Father Mother Other _____

Policy Holder: _____

Mailing Address _____ City _____ State _____ Zip _____
(If different from patient)

DOB of Insured (if not yourself): _____/_____/_____ Social Security # (if not yourself): _____ – _____ – _____

Insurance ID #: _____ Group #: _____

ALTERNATE CONTACT- Not living with you

NAME _____ RELATIONSHIP _____ PHONE(____)_____ DOB _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to include major/medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to Kevin B. Browne, M.D., P.A.. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent for medical care.

SIGNATURE _____ RELATIONSHIP _____ DATE _____

Kevin B. Browne, M.D., P.A.

4499 Medical Drive, Suite 330
San Antonio, Texas 78229
Phone: 210-615-8177 • Fax: 210-615-8884

Acknowledgment Form

I understand that as part of my healthcare, **Kevin B. Browne, M.D., P.A.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as.

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided*
- *And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.*

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of protected health information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this acknowledgment. I understand that Kevin B. Browne, M.D., P.A. reserves the right to change his practices and to make the new provisions effective for all protected health information maintained by Kevin B. Browne, M.D., P.A.

I understand that I have the right to request restrictions as to how my personal health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Kevin B. Browne, M.D., P.A. is not required to agree to the restrictions requested. Kevin B. Browne, M.D., P.A. will not use or disclose my health information without my authorization, except as described in the Notice of Privacy Practices.

Kevin B. Browne, M.D., P.A. records may contain information created by an entity other than Kevin B. Browne, M.D., P.A. Kevin B. Browne, M.D., P.A. is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). Patient expressly requests release of all records maintained by Kevin B. Browne, M.D., P.A. concerning patient, including incorporated records. Patient acknowledges that Kevin B. Browne, M.D., P.A. has not and assumes no duty to patient regarding the content of or omissions from such incorporated records.

_____ _____

Signature of Patient or Legal Representative **Date Signed by Patient or Legal Representative**

_____ _____

Witness **Date**

Kevin B. Browne, M.D., P.A. was unable to obtain acknowledgment/consent because:

❑ Emergency ❑ Patient Non-Responsive ❑ Patient Confused/Disoriented
❑ Patient Sedated ❑ Patient Refused - Reason _____

March 3, 2003
Effective Date of the Notice of Privacy Practices

MISSED APPOINTMENT

A **$25** FEE WILL BE ASSESSED FOR MISSED APPOINTMENTS.