Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

REGISTRATION FORM

(Please print)

PATIENT INFORMATION

Patient's last name: First: Middle:			❑Mr. ❑Mrs.	❑Miss ❑Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑Yes ❑No	If not so, what is your legal name?	(Former name):		Date of birth: / /	Age:
Street address:		Social security no.:			Home phone #: Cell phone #:
P.O. BOX:	City:		State:		Zip code:
Occupation:	Employer:				Employer's phone no.: ( )
Chose clinic because / Referred to clinic by (Please check one box):		❑Dr.		❑Insurance plan	❑hospital
❑Family	❑Friend	❑Close to home/Work	❑Other		Other relatives seen here:
Pharmacy:		Pharmacy phone number/address:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Date of birth: / /	Address (if different):			Home phone no.: ( )
Is this person a patient here? ❑Yes ❑No					
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ❑Yes ❑No					
Name of primary insurance	Address:				
Name of the primary insured:	Primary insured S.S. no.:	Date of birth: / /	Policy no.:	Group no.:	Copayment: $
Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other	
Name of secondary insurance (if applicable):	Primary insured name:		Policy no.:	Group no.:	
Patient's relationship to primary insured:	❑Self	❑Spouse	❑Child	❑Other	

IN CASE OF EMERGENCY

Name of local friend or relative (Not living at the same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 also authorize Jordan Mitchell MD or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

Providing professional care for your most intimate health needs.

APPOINTMENT POLICY- We value our patients and the time we spend with each of you and we like to set aside appointments that work well for your schedule. If there is a conflict with your appointment time, we ask that you call the office at least 24 business hours in advance to cancel or reschedule. **Appointments cancelled without a 24 business hour advance notice will be charged $25.** Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule to a different day. Any patient who no shows their appointment may be charged $25, and after three no shows the patient will be required to pay their copay prior to their next scheduled appointment.

WELL WOMAN EXAMS- Our goal at Jordan Mitchell MD is to put the patient first by providing outstanding service to each and every patient, each and every visit. In keeping with our policy to educate in the areas of medicine and insurance, we would like to let you know that if you are here for an annual well woman exam, we will only discuss details or perform services applicable to a well woman exam. If there are medical issues that you would like to discuss with Dr. Mitchell that fall outside of a well woman exam, you will be rescheduled for a problem visit at another date/time. If your problem is emergent, we will address the problem today but will be required to reschedule the annual well woman exam.

If for any reason a problem visit is handled on the same day as an annual visit, the insurance will be billed for each service separately. Depending on your personal insurance benefits, you may be responsible for any out of pocket costs associated with the additional services billed to insurance.

If you have any questions or concerns regarding this policy, please ask our staff.

MEDICAL INSURANCE- Your medical insurance is a benefit that your employer provides for you, or you purchase privately for yourself. Many times, understanding your benefits is confusing. We will do our best to assist you, however, because we are a third party, we have limited access to information regarding your medical benefits. Many plans have specific restrictions and you should consult your insurance handbook for these details.

Regardless of what we may calculate as your medical plan benefit, **you are responsible for the TOTAL cost of your medical treatment.** We will file the claim and do our best to process and coordinate payment from your insurance company.

Please keep in mind that **your insurance company does not guarantee your benefits** therefore we can only estimate your portion. We ask that you pay your estimated portion and deductibles at the time of service. If you are unable to pay this estimated portion today we will be more than happy to reschedule your appointment at a later date.

AFTER HOURS CALLS- We have a physician on-call 7 days a week for **emergencies only**. We appreciate your discretion in using this service as many issues or routine questions can be answered during office hours.

RELEASE OF MEDICAL RECORDS- Upon receipt of a signed medical release form, records will be released within 15 days for a $25 fee. Medical records may be transferred to another physician electronically at no charge.

MEDICATION REFILLS- Please allow our office 48 hours for prescription refills. Refills will be processed during our normal business hours.

CONSENT FOR CARE- I hereby consent to necessary examination, procedures and/or treatments prescribed by my physician, his/her assistants, or designee as is necessary in his/her judgment. I understand that I am under the care and supervision of my attending physician.

_____

Patient name *(printed)* Signature of Patient or Guardian

_____

Printed name of Guardian Guardian's Relationship to Patient Date

Jordan Mitchell M.D.
OBSTETRICS/GYNECOLOGY

Acknowledgement of Receipt of Privacy Notice- HIPPA

Under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can, and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree, then you are obliged to abide by such restrictions.

Authorization for Use and Disclosure of Protected Health Information

I_____, hereby authorize, Jordan L. Mitchell, M.D., P.A. to use and/or disclose the following **protected health information (PHI)** to:

Name_____ Relationship_____

Name_____ Relationship_____

□ **I DO NOT** authorize Dr.Mitchell to release my PHI to anyone other than myself. I understand that by doing so it may take longer to get results.

May we leave a voicemail regarding medical information and/or financial responsibility? □ YES □ NO □ Cell □ Home □ Work

This PHI is being used or disclosed for the following purposes:

Provide appointment reminders and financial responsibilty.
Describe or recommend treatment alternatives
Provide information about health-related benefits and services that may be of interest to the individual.
Soliciting funds to benefit the covered entity

I understand that I have the right to revoke this authorization at any time by submitting a written request and that a revocation is not effective prior to the revocation date. Furthermore, I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I also understand that I have the right to refuse to sign this authorization and my treatment or eligibility for benefits will not be conditioned upon this authorization. The use or disclosure requested in this authorization will result in direct and indirect compensation to **Jordan L. Mitchell, M.D., P.A.** from a third party. This authorization will remain in effect until further notice from patient or legal guardian of the patient.

_____ _____

Signature of the Patient or Representative/Guardian Date

_____

Printed Name of Patient or Representative/Guardian

Jordan Mitchell M.D.
OBSTETRICS GYNECOLOGY

5757 Warren Pkwy Ste 240 Frisco, TX 75034 Phone: 214-297-0008 fax: 214-297-0001

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date: _____

Previous Name: _____ Date of Birth: _____

I request and authorize Dr. Jordan Mitchell to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All Healthcare information

Reason for release:

☐ Personal Use ☐ Transferring Care ☐ Insurance request ☐ Other

This authorization includes the release of information about the following, if it included in the medical record, AIDS, HIV related information or testing, psychiatric disorders, drug treatment, and/or alcohol treatment. The specific dates of such records to be disclosed include:_____ I hereby agree to this authorization and understand that it must contain Personally Identifiable Information and PHI as defined in HIPAA to ensure accuracy. I understand that I have a right to limit the type of information release and to revoke this authorization by submitting a notice, in writing to you. Unless revoked, this authorization will expire on the following date: _____. If I chose to limit the information released, I understand that you may inform the requestor that portions of the record have been withheld. You are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized herein.

I understand that information will be provided within 15 days from receipt of request and a fee for preparing and furnishing this information may be charged to me according to the rulings set forth by the Texas State Board Of Medical Examiners.

_____

Patient Name {Printed} Signature of Parent or Guardian

_____

Printed Name of Guardian Guardian's Relationship to Patient

Date: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED

Jordan Mitchell MD
Obstetrics/Gynecology

If your child needs medical, dental or hospital services, a parent must give permission. It's the law. What about times when you cannot be reached for permission? A child may be treated without parental consent when a physician determines a true emergency exists. That means the doctor determines the child needs immediate medical care and that an attempt to obtain parental consent would result in a delay which would increase the risk to the child's life or health.

Except in a true emergency, care may be ordinarily rendered to a child only with the consent of the parent or legal guardian. Sometimes a child may need unexpected care which is not, however, a true emergency. In such cases, making an effort to contact a parent for permission can delay treatment and create unnecessary anxious moments for the child.

You can prepare for unexpected care your children might need when you are away from home. To do this, make sure babysitters know how to reach you at all times. And when you know you will be hard to reach, you can give permission to other adults. They can then act for you by permitting your child to be treated if unexpected care is needed.

This is a legal document. With it you may appoint relatives, friends, teachers, clergy, neighbors- anyone who is over 18 years of age- to be responsible for your children when you are away from them. It is especially important to prepare this form for the occasions, when you know it will be hard to contact you.

Fill out this form, give it to the adult(s) you have named to act on your behalf. If your child needs unexpected medical treatment, the responsible adult(s) should present this document to the appropriate person- physician, dentist or hospital representative.

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

Name of Minor(s)	DOB	Allergies/ Special Conditions

I/ We, being the parent(s) or legal guardian(s) of the above named minors(s), do hereby appoint:

Name	Address	Phone #

To act in my/our behalf in authorizing unexpected medical, dental, surgical care and hospitalization for the above named minors(s) during the period of my/ our absence, from: _____

This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental, surgical care or hospitalization may be required.

_____ _____
Signature of Parent / Guardian **Address**

_____ _____
Signature of Parent / Guardian **Address**

_____ _____
Signature of Witness **Address**

_____ _____
Signature of Witness **Address**

Hospitalization Coverage for above Named Minor(s)

Insurance Company or Government Program ID or Contact #

_____

Family Physician:
Name: _____ **Phone:** _____

All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted – with the advice of the organization's attorney – to meet state, local, individual organizations and department needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust, nor Texas Medical Insurance Company, nor Lone Star Alliance, Inc., a Risk Retention Group, is engaged in rendering legal services.

Revised 09-25-06

NOTICE OF PRIVACY PRACTICES FOR JORDAN MITCHELL, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPAA" provides penalties for covered entitles that misuse personal health information.

As required by ("HIPAA") we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We can also create and distribute, de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the privacy officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a restriction request. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of your protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14 th 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new Notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised notice of privacy practices from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

For more information about HIPAA or file a complaint:
The U.S. Department of Health & Human Services Office of civil rights
200 Avenue, southwest of independence
Washington, DC 20201
(202) 619-0257
Toll free: 1-877-696-6775

Patient/Guardian signature_____ Date_____

Well Woman Exam

Our records indicate that you have been scheduled today for a well woman exam. The exams are also known but not limited to, the following terms:

Well Woman Exam
Annual Pap and Pelvic Exam
Pap
Pap/Pelvic/Breast Exam
A Female Exam
Yearly, Routine, Female Exam

This service will be coded by our office as a Well Woman Exam. Your insurance may or may not cover this exam.

If you or the healthcare provider you are seeing today, decide to have LAB WORK done, please note that the reference laboratory contracted by your insurance company will bill the insurance company for all the laboratory test performed by them. The laboratory service May or MAY NOT be covered by your insurance plan as part of the well woman exam.

Please keep in mind that services provided today that go above and beyond the normal scope of a Well Woman Exam will be billed to your insurance company with the appropriate diagnosis and office visit codes. It is your responsibility to know if you have insurance benefits for wellness, preventive, well woman or health screening. All services for today's visit whether billed by this office or the refence laboratory that are not paid by insurance, are your financial responsibility.

Our physicians feel that periodic, routine physical examinations with certain diagnostic laboratory test or other age appropriate procedures, are an integral part of providing excellent healthcare to their patients.

By signing below, you acknowledge and accept financial responsibility for all non-covered services, and /or services that you your insurance company delegates as your responsibility that are associated with today's visit.

_____

Patients Printed Name Date of Service

_____

Signature of Patient Patients DOB