Carol N Abalihi MD PA
3030 Joe Battle Ste. B
El Paso, TX 79938
Phone: 915-225-4470

Patient Registration

(Registración del Paciente)

Name: ______________________________ **DOB**____________**M/F Marital Status S M W D SEP**
(Nombre) (Fecha De Nacimiento) (Sexo) (Estado Civil)

SSN: ______________________ **Email Address:** _________________________ **Student Yes/No**
(Seguro Social) (Correo Electrónico)(Estudiante)

Mailing Address:_________________________ **City/State/Zip:** ____________________________
(Dirección) (Ciudad, Estado, Código Postal)

Main Phone #:___________________________ **Alternate Phone #:**________________________
(Teléfono) (Alternativo)

Occupation/Employer:____
(Ocupación/Empleador)

Race (Choose Only One) Caucasian African America Asian Hispanic Native American American Indian Alaskan Native Hawaiian More than one race Other:___________

Spouse Name:________________ **DOB:**____________ **SSN:**____________ **Phone:**____________
(Nombre de Esposa/o) (Fecha De Nacimiento) (Seguro Social) (Teléfono)

Emergency Contact:__________________**Relation:**__________________**Phone:**__________
(Contacto de Emergencia) (Relación) (Teléfono)

Reason for Visit:____
(Razón de la visita)

Pharmacy:____________________________**Pharmacy Address:**____________________________
(Farmacia) (Dirección De La Farmacia)

Do you have an Advanced Directive? Yes / No **Do you smoke? Yes / No**
(Tiene una Directiva Anticipada) Si/ No(Fuma?) Si/ No

Patient Signature:____
(Firma del Paciente)

PAYMENT IS REQUIRED AT THE TIME OF SERVICE
(EL PAGO ES REQUERIDO EN TIEMPO DE SERVICIO)

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RECORDS RELEASE AUTHORITY

DATE: ______________

TO: ____
DOCTOR/HOSPITAL

ADDRESS: ____

CITY: ______________________ STATE:____________________ ZIP:__________

__Entire Medical Record
__Operative Report
__Laboratory/Pathology Reports
__Radiology Reports
__Sleep Study Reports
__Substance Abuse/Dependency
__Psychiatry/Mental Health Treatment
__HIV/Aids Information
__Sexually Transmitted Disease Test/Treatment
__Other______________________________

Patient Name: ____
DOB: ________________ SSN: ________________________ Date: ____________
Patient Signature: ____
Witness/Office Staff: ________________________________ Date: ____________

PERSON REQUESTING MEDICAL RECORDS OTHER THAN THE PATIENT

Name: ______________________________ Relationship to patient: ______________

Signature: ______________________________________ Date: ________________

This consent is effective from today and will expire upon request. I understand that information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law.

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CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, ____, whose signature appears below, authorize Carol N Abalihi MD PA and its Affiliated Providers to view external prescription history via Rx Hub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefits manager may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE BELOW CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

SIGNATURE: ____

DATE: ____

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BILLING POLICY

- The following sets forth the general billing policy of Carol N Abalihi MD PA with current accurate billing information at the time of check-in and notify of any changes in this information.
- I understand that it is my responsibility to know my office co-pay and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the office also has contractual agreement with my health plan to collect co-pays at the time of services, and they are required to report to the carrier any enrollees falling to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that pay with cash , a money order, cashier's check, or credit card.
- I understand that there is a $25 fee to complete each paperwork (such as FMLA, Disability Handicap Parking Permit, School Physical) brought in by you and be completed by the office. Copy of vaccination record fee $10.
- I understand that the office will verify insurance eligibility, deductible amount, and co-insurance amounts prior to my office visit that I may have. I further understand that it is the policy to collect the deductible and/or co-insurance prior to my office visit. I further understand that the FEE I AM QUOTED IS AN ESTIMATE based on anticipated care in the office for the day.
- I understand that I will be billed for any amounts due by me (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice," and may be sent to an outside collection service if interest or legal expenses associated with the collection effort.
- I understand that the office will obtain the necessary authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I understand the office may also take verbal request to use my listed credit card for payment on my account or it may also use the same listed credit card on my account should my account be delinquent, or to cover an NSF check.

  MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ THESE BILLING POLICIES AND MY FINANCIAL OBLIGATION AS PERTAIN TO THE PHYSICIAN CAROL N ABALIHI MD PA

Signature: ____

Relationship to Patient: ______________________________________

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ASSIGNMENT OF BENEFITS

Patients Name: ____________________
Street Address: ____________________
City: ____________ State: ____________ Zip: ________
Phone: ____________

I request that payment of authorized Medicare/ other insurance company benefits be made on my behalf to Carol N Abalihi MD PA for any services furnished to me by that party who accepts assignments. I authorize any holder of medical or other information or its intermediary's carrier or any other insurance company claim. If item 9 of HCFA-1500 claim forms is completed, my signature authorizes releasing supplier agrees to accept the charge determination, and none covered services.

Co-insurance and deductible are based upon the charge determination by Medicare/other insurance company. In the event it is necessary to refer this account to a collection agency or attorney fees. If more than one individual executes this agreement, their liability shall be joint and several. All questions about fees should be asked prior to services being rendered. The person responsible for payment, please sign below having read and understanding all the above regarding information.
I am responsible for balance of my bill, after my insurance has responded. In the event I do not have insurance or my insurance is not valid, I am responsible for the balance of my bills entirely. I HAVE RECEIVED/READ A COPY OF THIS PRIVACY POLICY.

SIGN: ____________________ DATE: ____________

IF SOMEONE OTHER THAN THE BENEFECIARY IS SIGNING THIS FORM, PLEASE COMPLETE THE FOLLOWING FOR THE PERSON SIGNING THIS FORM.

RELATIONSHIP TO BENEFICIARY: ____________ PHONE: ____________
STREET ADDRESS OF THE PERSON SIGNING THIS FORM: ____________
CITY: ____________ STATE: ______ ZIP: ____________

REASON WHY BENEFICIARY CANNOT SIGN THIS FORM: ____________ BY SIGNING ON BEHALF OF THE PATIENT, I ACKNOWLEDGE THAT I HAVE AUTHORITY TO DO SO.

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- 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: ______________________________ (PRINT NAMEPLEASE)

Signature: ______________________________ Date ______________

Witness: ______________________________ Date: ______________

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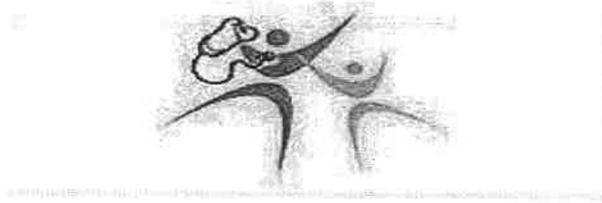
APPOINTMENT

If you are unable to keep appointment, contact us our office as soon as possible. All NO SHOW and Cancellations made with less than 24 Hours Notice will be subject to a $25 charge added to your next appointment.

Signature:______________________________

Date:__________________________________



Carol N Abalihi MD PA

We'd Like your feedback

Name ____________________________ DOB _______________

I would like to receive communication by email Y/N

Email address ___________________________________

I would like to receive communication by telephone Y/N

Phone Number __________________________________

I would like to receive communication by Text Message Y/N

Mobile Number __________________________________

No thank you I do not wish to receive communication by post _____ (initial)

Signature ________________________________ Date _________

TEXAS VACCINES FOR CHILDREN (TVFC) PROGRAM
PATIENT ELIGIBILITY SCREENING RECORD

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children Program must be kept in the health care provider's of ce. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening must take place with each immunization visit to ensure the child's eligibility status has not changed. This same record will satisfy the requirements for all subsequent vaccinations, as long as the child's eligibility has not changed. If patient eligibility changes, a new form must be completed. While veri cation of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

Date of Screening: ______________________
mm/dd/yyyy

Child's Name: ____
Last Name First Name MI

Child's Date of Birth: ______________________ Age: _____
mm/dd/yyyy

Parent/Guardian/Individual of Record: ____
Last Name First Name MI

Please check the rst category that applies; check only one.

(a) ☐ Is enrolled in Medicaid, or

Medicaid Number: ______________ Date of Eligibility (mm/dd/yyyy) ______________

(b) ☐ Is an American Indian, or

(c) ☐ Is an Alaskan Native, or

(d) ☐ Does not have health insurance (uninsured), or

(e) ☐ Is a patient who receives bene ts from the Children's Health Insurance Plan (CHIP) and is being seen at a facility that bills CHIP, or

CHIP Number: ______________ Date of Eligibility (mm/dd/yyyy) ______________

(f) ☐ Is underinsured:

- ☐ 1) has commercial (private) health insurance, but coverage does not include vaccines; or
- ☐ 2) insurance covers only selected vaccines (TVFC-eligible for non-covered vaccines only); or
- ☐ 3) insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

(g) ☐ Has private insurance that covers vaccines:

Name of Insurer: ______________________ Insurer Contact Number: (____) __________
Area Code + number

Policy/Subscriber Number: ______________________ Group Number (if applicable): __________

NOTE: Knowingly falsifying information on this document constitutes fraud. By signing this form, I hereby attest that the above information is true and correct. I declare that the person named above is an authorized person and is eligible to receive TVFC vaccines.

Signature: ______________________________ Date: ______________
(mm/dd/yyyy)

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Noti cation. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Clinic Use Only

I certify any services for CHIP members will be billed to CHIP; ☐ Yes ☐ No

TVFC Eligible: ☐ **Yes** ☐ **No**

Screener's Initials: __________

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
IMMUNIZATION REGISTRY (ImmTrac)
ADULT CONSENT FORM

(Please print clearly)

Last Name

For Clinic/Office Use

First Name

Middle Name

Date of Birth ___/___/___

Gender: ☐ Male ☐ Female

Address

Apartment #

Telephone ___-___-___

City

State

Zip Code

County

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac. *For a family member younger than 18 years of age, a parent, legal guardian or managing conservator may grant consent for participation for that minor by completing the ImmTrac Minor Consent Form (# C-7). The ImmTrac Minor Consent Form (# C-7) can be downloaded by visiting www.ImmTrac.com.*

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration and Release of Immunization Records to Authorized Persons/Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry, ImmTrac. Once in ImmTrac, my immunization information may by law be accessed by:

- a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient;
- a Texas school in which the individual is enrolled;
- a Texas public health district or local health department, for public health purposes within their areas of jurisdiction;
- a state agency having legal custody of the individual;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy.

I understand that I may withdraw this consent at any time.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): ______________________
Printed Name

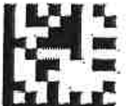
______________________ ______________________
Date **Signature**

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. EF11-13366
Revised 05/18/12



***PROVIDERS REGISTERED WITH ImmTrac** – Please enter client information in ImmTrac and affirm that consent has been granted. DO NOT fax to ImmTrac. Retain this form in your client's record.*

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BILLING PURPOSES ONLY

NAME OF PATIENT: ______________________________ DATE: __________________

NAME ON CREDIT CARD: ___________________________ DATE: __________________

CREDIT CARD NUMBER: ____________________________ DATE: __________________

TYPE OF CREDIT CARD: ___________________________ DATE: __________________

VALID DATE: ___________________________________ DATE: __________________

EXPIRATION DATE: ____

SECURITY CODE: _________________

Carol N Abalihi MD PA

3030 Joe Battle Ste B
El Paso TX, 79938
PHONE: 915-225-4470
FAX: 915-533-8055

Authorization- Non Parent / Guardian to Accompany patient

Authorization- non parent / guardian to accompany patient periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child. The person bringing your child will need to present photo identification at time of service.

The authorization gives the person permission to bring your child in, speak to the doctor, give authorization for treatment, vaccinations, medication, and certain procedures and make general health decisions.

Fist Name (Parent/Guardian) ____________________ Middle Initial ________ Last name _____________

I, (parent/guardian named above), give the person(s) listed below permission to bring my child to Carol N Abalihi MD PA and to discuss/share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is an emergency nature to where there is no sufficient time to seek out my specific consent.

First Name (Patient) ______________ Middle Name __________ Last Name ________________

Date of Birth

___/__/_____

Name of person (allowed to bring child) _____________________ Relationship ______________

Name of person (allowed to bring child) _____________________ Relationship ______________

Parent/Guardian Signature ________________________ Date ___/___/____