Shane E. Keller, M.D. • Caroline Brown, APRN • Michele Graczyk, APRN
505 W. Louis Henna Blvd., Ste. 100 Austin, TX 78728
Phone: 512.252.1505 • Fax: 512.252.1506 • www.parkwayprimarycare.com

New Patient Registration Forms

Welcome to Parkway Primary Care! In order to better serve you, we will need the following information. (Please Print)

Patients First and Last Name	Sex M F	Date of Birth ____/_____/_____ Age _________	Social Security Number _______-_______-_______	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]

Mailing Address	City	State	Zip	Email Address

Home Phone	Cell Phone	Work Phone	Preferred Contact Method

Emergency Contact	Relationship to patient	Phone Number

Race I prefer not to answer African American or Black American Indian/Alaska Native Asian Native American/Pacific Islander White	Ethnicity Hispanic or Latino Not Hispanic or Latino

Preferred Pharmacy	Phone Number

Primary Insurance Company	Address	City	State	Zip

Guarantor First and Last Name	Guarantor Date of Birth	Member ID #	Group #

Secondary Insurance Company	Address	City	State	Zip

Guarantor First and Last Name	Guarantor Date of Birth	Member ID#	Group#

Consent for treatment

I hereby consent to necessary examination procedures and /or treatment by my physician, his/her assistants, designees as is necessary in his/her judgement.

Date__________ Signature(patient/guardian)____Relationship if guardian_____________________

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PATIENT FINANCIAL POLICY

Parkway Primary Care is dedicated to providing the best possible care and service to you, as well as ensures that you have a complete understanding of your financial responsibilities. Please understand that payment of your bill is considered a part of your treatment. If you have any questions regarding these policies, please discuss them with our Office Manager.

***Patients with a deductible plan of over $500 will be required to pay $75.00 at the time of service. This is a prepayment of your statement and is possible that an additional amount may be owed once the claim has been filed with your insurance.**

PAYMENT

Full payment is due at the time of service. We accept cash and all major credit cards. We do not accept checks. Understand payment for your office visit does not include that of procedures, vaccines, injections or labs. This will be subject to your plan benefits and rendering these costs will be due at the time of service. Charges not covered by your insurance will be patient responsibility. **MINOR PATIENT :**For all services rendered to minor patients, we will look to the adult accompanying the patient or the adult authorizing services to be rendered for the patient for payment.

NO INSURANCE

Private pay patients will receive a prompt pay discount for payment in full at the time of service. Please keep in mind, any labs, procedures, injections or vaccines will be an additional cost due at the time of service. If you are unable to pay the full price of the prompt pay discount and have to make an arrangement, the discount is void and the full cost of service will be applied.

INSURANCE

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the amount you are responsible for under the terms of your insurance contract (i.e. co-payment, co-insurance, deductible, non-covered services).In the event that your health plan deems a service “not covered” you will be responsible for the complete charge.

MISSED APPOINTMENTS

*Appointments must be canceled at least 4 business hours from the scheduled appointment time in order to avoid the late cancellation/no-show fee of $50.00. This fee is not paid by your insurance company and will be due at your next appointment. If you run late and fall into your scheduled appointment time we will do our very best to fit you in on that same day. Please be aware that there are days with limited flexibility in the schedule. In the event that this is the case, please be prepared to reschedule your appointment for another day as well as pay the $50.00 missed appointment fee.

STATEMENTS & COLLECTIONS

*Statements are sent monthly and are due upon receipt. Please contact our office to set up payment arrangements if necessary. Please note that you will be asked to pay your balance should you come in to the office for an appointment. You can also pay balances by going online to www.parkwayprimarycare.com . Please remember to put the patient name of which the bill belongs to and the amount for proper processing. If unable to pay with any other form of payment, you may mail a check. If the check is returned by our bank, a $25.00 returned check fee will be assessed to your account. Payment for the amount of the check and the $25.00 fee will be due before your next appointment can be scheduled.

If after 60 days, your payment has not been received, your account will be subject to collections and a fee of 30% of the balance due will be added to your account.

I have read, understand and agree with the financial policy of Parkway Primary Care.
I authorize my insurance benefits to be paid directly to Parkway Primary Care. I authorize Parkway Primary Care to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
I understand and agree that Parkway Primary Care may amend these terms from time to time.

Date___________ **Signature** (patient/guardian)________________________________ **Relationship**_________________

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GENERAL OFFICE INFORMATION & PHILOSOPHIES

- Our hours are 8:00AM to 5:00PM, Monday through Friday. Closed from 12-1 for lunch.
- You must notify us of any changes in your address, phone numbers or insurance coverage. Failure to report updated information in a timely manner could result in the denial of an insurance claim or delay the delivery of time sensitive information.
- We encourage use of email; but it is NOT appropriate for urgent or time-sensitive matters. Please refer to using the patient portal for direct communication to staff if unable to call. We cannot diagnose or render treatment, nor fill medications by email.
- Prescriptions are sent electronically to the pharmacies for safety and security reasons.
- **Please allow 48 hours for refill requests. When refilling a prescription, we ask that you directly contact the pharmacy and they will fax a request directly to us**.
- **If it is discovered that a patient is abusing an addictive/narcotic medication, receiving multiple prescriptions from multiple physicians or using multiple pharmacies without notifying us, our doctor-patient relationship will be terminated with a 30 day grace period allowed in order to transfer to another physician. In those 30 days, there will be no treatment or prescriptions provided for any pain related condition.**
- Clerical, administrative and paperwork tasks are not paid by insurance companies and are not billed to them. Our fee is $50.00 per occurrence and the patient/guardian is responsible for these charges (examples include, but are not limited to processing FMLA paperwork, etc.).
- We do not release your medical records/information without properly signed authorization. Our charge for medical records issued directly to patient is $30.00 and is due by the patient/guardian at the time records are obtained.
- We will not provide continuing care to patients who make requests that are illegal, unethical, or fraudulent.
- As a courtesy to our patients, our staff makes considerable effort to assist you with many issues that are not always within the control of our office. Please do not verbally/physically abuse our staff for any reason.

I have read, understand and agree with the General Office Information & Philosophies of Parkway Primary Care.

Date___________ **Signature** (patient/guardian)________________________________ **Relationship**_________________

Notice of Privacy Practices

Our full Notice of Privacy Practices is located both online and in a binder at the Front Desk of our office. Once you have reviewed it please sign below. If you would like a copy to take home, please notify the Front Desk and we will get a copy for you.

I have reviewed Parkway Primary Care's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this documentation.

Date___________ **Signature** (patient/guardian)________________________________ **Relationship**_________________

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Release to Share Medical Information

We will not be able to disclose information regarding your care to anyone who is not on this list.

I designate the following person(s) to be able to speak with the staff at Parkway Primary Care on my behalf about my medical condition or the status of my account. I release Parkway Primary Care and its staff from any claim of confidentiality with the release of this information.

Last Name____________________________ First Name__________________ M.I____ Birth Date_________________
Home Phone__________________________ Work Phone________________________ Cell Phone_________________

Last Name____________________________ First Name__________________ M.I____ Birth Date_________________
Home Phone__________________________ Work Phone________________________ Cell Phone_________________

Date__________ **Signature** (patient/guardian)________________________________ **Relationship**_________________

Informed Consent to use Patient Portal

Parkway Primary Care is offering this secure, HIPAA compliant communication tool as a courtesy to our patients and their parents. It is an optional service and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly as possible. We will never purposefully share this information with any third party.

Through the Patient Portal you will have the ability to communicate with office staff as well as receive lab/x-ray results more quickly than by regular mail.

By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Parkway Primary Care or any of their staff liable for network infractions beyond their control.

Privacy and Security

The web portal or webpage has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information/communications to us. To help ensure that the tunnel remains secure, we need to have your current (private) email address and be informed if it ever changes. If you think someone has learned your password, immediately go to the portal site and change it.

Confidential email (please print clearly): ____

Patient Name: ______________________________**Date of Birth**: _______________________

Print name of Parent/Guardian requesting access:____

Signature: ____ **Date**: _____________________________

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Release of Medical Records

Name of Patient: ____

DOB: ____________________ Social Security Number: ____________________

I authorize the release of my protected medical records as requested below:

☐ **To** ☐ **From** Parkway Primary Care
505 W. Louis Henna Blvd., Ste. 100
Austin, TX 78728
Phone # (512)252-1505 Fax# (512)252-1506

Attention: ☐ **Shane E. Keller, MD** ☐ **Tina J. Philip, DO** ☐ **Ann-Marie Koch, FNP**

☐ **To** ☐ **From** ______________________________
____
____
Phone#: ______________________________
Fax#: ______________________________

Are you transferring care? YES NO

Dates Requested: *Last 2 Years only* unless otherwise specified below:

From: ____________________ **To:** ____________________

Information to be released: (Reports may include information on drug / alcohol / psychological / HIV or communicable disease treatment.)

Records requested:

☐ History & Physical ☐ Consultations ☐ EKG ☐ HIV/AIDS ☐ Progress Notes
☐ Laboratory ☐ Radiology/MRI/CT ☐ Other ☐ All Medical Records

Purpose for release of information:

☐ Personal Use ☐ Legal Purposes ☐ Insurance ☐ Continuing Medical Care
☐ Social Security/ Disability ☐ Other

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/ state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Date____________________ **Signature** (patient/guardian)______________________________

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Covid Screening Questions

Paitent Name: ______________________________ DOB: ____________________

Please do not complete this form until the day of your appointment

Today is ______________________________, 20________

Are you experiencing any of the following symptoms today? Please specify details if "Yes":

Fatigue	Yes	No	
Cough	Yes	No	
Shortness of Breath	Yes	No	
Fever	Yes	No	
Chills	Yes	No	
Sore throat	Yes	No	
Congestion	Yes	No	
Runny nose	Yes	No	
Headache	Yes	No	
New loss of taste or smell	Yes	No	
Have you been directly exposed to someone with confirmed COVID-19?	Yes	No	
Have you traveled by air within the last 2 weeks?	Yes	No	