Uvalde Family Practice Association
1800 Garner Field Road
Uvalde, Texas 78801
(830)278-4453

Welcome to Uvalde Family Practice Association. We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality of care for all of our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and have early availability with our physicians. You will need to bring your insurance card with you for each appointment and verify your date of birth. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually so we may update your information.

All co-pays and past due balances are expected at time of service, unless a prior agreement has been made with our billing department.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late.

We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Please bring all of your prescription(s) and over-the-counter medications with you at each visit.

We understand that appointments sometime need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment.
Our office policy for a missed appointment is:

- Two (2) no-show appointments without a phone call may result in dismissal from the practice.

Providing the highest quality of professional care to our patients is very important to us.
If you need to reach the physician after hours, you can always reach our answering service at (830) 278-4453 which the on-call physician will be contacted. Our office hours for patient care are 9:00 am – 4:30 pm.

Welcome to our practice and thank you for choosing Uvalde Family Practice Association for all your health care needs.

_____
Signature of Patient or Legal Guardian

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Patient Information Form

Patient Demographics

First Name _____ Middle Name _____ Last Name _____

Date of Birth ____ / ____ / ____ Language _____ SSN _____

Permanent Address _____ Apt.# _____ City _____ State _____ Zip Code _____

(____)_____-_____ (____)_____-_____
Preferred Phone Number Alternate Phone Number Email Address

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Gender: ☐Male ☐Female

If Married Spouse's Name: _____ Spouse's Employer _____

Race: ☐African American ☐American Indian/Alaska Native ☐Asian ☐Hispanic ☐Mixed Race ☐White ☐Other ☐Refuse to Report

Ethnicity: ☐Hispanic ☐Not Hispanic ☐Refuse to Report

Pharmacy

Preferred Local Pharmacy: _____

Emergency Contact Information

Contact Name _____ Phone Number _____ Relationship to Patient _____

Do you have a medical directive? ☐YES ☐NO Do you have a power of attorney? ☐YES ☐NO

Patient Employment Information

Employer Name _____ (____)_____-_____
Employer Phone Number

Medical Insurance Information

Policy Holder's Name _____ Policy Holder's SSN _____ Policy Holder's Date of Birth ____/____/____

Policy Holder's Address _____ (____)_____-_____
Policy Holder's Phone Number

Insurance Company _____ Group Number _____ Policy Number _____

Do you have secondary insurance? ☐YES ☐NO If yes, please list: _____

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Patient Rights and Responsibilities

When you are seen by an employee of Uvalde Family Practice Association:

You have the Right:

- To be treated with consideration, respect and dignity.
- To have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- To have privacy during case discussion, counseling and treatment.
- To know the name and qualifications of staff providing your care.
- To know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand.
- To expect that all services, treatment, and counseling techniques will take place with your informed consent.
- To participate in referral planning, if needed.
- To refuse to participate in research studies.
- To have another individual present in the exam room with you, if you so desire.

You have the Responsibility to:

- Treat the staff with consideration, respect and dignity.
- Understand that your life-style does affect your health.
- Take an active part in your health care.
- Follow the agreed upon treatment plan.
- Observe facility rules and regulations that are for the safety and consideration of all patients and staff.
- Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Patient Name (printed): _____

Patient/Guardian Signature: _____ Date_____

☐Self ☐Relationship to Patient _____

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Patient Consent for HIPPA

I understand that I/the patient have certain rights to privacy regarding my/the patient's protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my/the patient's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my/the patient's protected health information and my/the patient's rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I/the patient have the right to request restrictions on how my/the patient's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Uvalde Family Practice Association and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Uvalde Family Practice Association.

I authorize payment of medical benefits to Uvalde Family Practice Association physicians or their designee for services rendered.

I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name (printed): _____

Patient/Guardian Name (signature): _____

☐Self ☐Relationship to Patient _____

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Authorization for Release of Information to Family Members or Family Caregivers

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

☐ I do not authorize to release my medical and/or billing information.

☐ I authorize Uvalde Family Practice Association to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time, any revocation must be in writing.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. Uvalde Family Practice Association has no control over third party dissemination of protected medical information.

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Name (printed): _____

Uvalde Family Practice Assn.

Lawrence P. Wegrzyn, M.D.
Cherie Hauptmeier, D.O. Andrew M. Rahaman, M.D.
Jane D. Champion, Ph.D., C.S., F.N.P. Lauren Rothe, M.S.N., R.N., F.N.P-C
Kimberly VanDalen, M.S., R.N., N.P-C
1800 Garner Field Road
Uvalde, Texas 78801

Tel. (830) 278-4453
Fax (830) 278-3427

Authorization Form
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below:

Patients Name: _____ Date of Birth: _____

The health information you may release subject to this authorization is as follows:

_____

Release my protected health information to the following entity:

Uvalde Family Practice Association
1800 Garner Field Road
Uvalde, Texas 78801
Fax Number: (830) 278-3427

The reason or purposes for this release of information are as follows:

_____

This authorization shall be in force and effective until the following event and/or date: _____

I understand that I have the right to revoke this authorization in writing, at any time by sending a written notification to the following:

Uvalde Family Practice Association

I understand that the revocation is not effective to the extent that the practice has relied on this authorization in its action. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations. The practice will not condition my treatment, payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority