



# LAKE TRAVIS MEDICAL CENTER

Please present Drivers license and Insurance cards to receptionist.

## PATIENT INFORMATION

(PLEASE PRINT NAME AS IT APPEARS ON INSURANCE.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M F Social Security # \_\_\_\_\_

Marital Status: S M D W Drivers License # \_\_\_\_\_ Date of Expiration \_\_\_\_\_ State \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Patient Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone #: \_\_\_\_\_

## REASON FOR TODAY'S VISIT

Symptoms: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Name of Health Insurance: \_\_\_\_\_ **Work Related:** Y or N **Caused by Assault or Collision:** Y or N

## POLICY HOLDER (THIS IS THE INDIVIDUAL THAT IS RESPONSIBLE FOR THE INSURANCE.)

Relationship to Patient \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Drivers License # \_\_\_\_\_ Sex: M F Marital Status: S M D W

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## PAYMENT

Lake Travis Medical Center requires payment at time of service. If you do not have insurance or we do not accept your current insurance, our average new patient charge is \$140, which does not include labs, x-rays, and/or diagnostic testing.

**Method of Payment: (check one)** Cash \_\_\_\_\_ Check \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I also authorize Lake Travis Medical Center or my insurance company to release any information required to process my claim.

X  
**Patient/Legal Guardian's Signature**

X  
**Date**

## PRIVACY PRACTICES ACKNOWLEDEMENT

I have reviewed this office'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 document.

**Signature of Patient** (or Personal Representative): \_\_\_\_\_

**Printed Name of Patient** (or Personal Representative): \_\_\_\_\_ **Date:** \_\_\_\_\_

## FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and Lake Travis Medical Center, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless either you or your health insurance carrier has made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept cash, checks, Visa, and MasterCard.

### PATIENT PAYMENTS

Payment is due at the time of service. You may use cash, check, Visa, and MasterCard to pay your account.

### INSURANCE PAYMENTS

Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payment or prepayment amounts depending on the type of insurance and insurance carrier. ***Be assured our office works diligently to obtain payment from your insurance company. However, If we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception.*** In the event that your insurance pays us after that time, you will be reimbursed.

### INSURANCE COVERAGE

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. In addition, be aware that some and perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services, services applied to your deductible or co-insurance at the time they are rendered. Finally, in the event you provide incorrect insurance information that delays payment, you may be asked to pay full billed charges and seek reimbursement from your insurance provider directly.

**\*\*Lake Travis Medical Center is not a Medicaid provider; your claim will not be covered. Initials: \_\_\_\_\_**

### THIRD PARTY PAYORS

Our office does not bill third party payors such as PIP (Personal Injury Protection) for a motor vehicle accident, workers compensation, or attorneys.

### RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a \$30.00 handling fee. If a second check is presented that is returned from the bank, we request that future visits be paid with Cash, Visa, or MasterCard.

### ***-Patient Authorization-***

I have read, understand, and agree to abide by the terms stipulated above. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original. This authorization shall remain valid until revoke by me in writing.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Signature** (or Parent of minor/Legal Guardian): **X** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of person completing form if other than patient:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

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