Ibn Sina Foundation

Ridgemont Family Clinic
In collaboration with FBISD

REGISTRATION FORM

PATIENT INFORMATION

First Name/Nombre:	Last Name/ Apellido	MI	DOB: __/__/__ Fecha de Nacimiento	Sex: □ Male □ Female □ Other _____

Address/Direccion:	City/Ciudad:	State/Estado:	Zip Code/Codigo Postal:	County/Condado:

Email Address/ Dirección de correo electrónico:	Home Phone #/ Nomero de Tel	Cell Phone #/Numero de cellular	Language/ Idioma: _____ Need Translator: ☐Yes ☐No

Occupation Ocupacion:	Race/ Raza: □ Hispanic □ Black □ Asian □ Native American □ White (Non-Hispanic) □ Other	Ethnicity/ Etnicidad:	Marital Status/Estado: □ Married □ Single □ Widowed □ Separated □ Divorced □ Other	Highest Grade Completed/ Grado más alto completado: □ Middle School □ High School □ Bachelors □ Masters □ Other___

Pharmacy Information	Name of Pharmacy	Phone #	Address

Emergency Contact Information

Contact Name/ Nombre de contacto:	Relationship/ Relación:	Telephone #/ Teléfono#:

How did you hear about us? / ¿Cómo supiste de nosotros?

☐ Word Of Mouth ☐ Friend/Neighbor ☐ Google ☐ Facebook ☐ Other social media _____

☐ Health Fair ☐ Walk-In ☐ Outside Agency ☐ FBISD ☐ Other_____

Would you like us to contact you for new programs, services, or promotions? ☐ Yes ☐ No

FINANCIAL POLICY: All professional services rendered by Ibn Sina Foundation are charged to the patient. All services provided to you as a patient of Ibn Sina Foundation are payable at time of service and are the sole responsibility of you "the patient" and/or guarantor of Minor (your children). I hereby authorize Ibn Sina Foundation to furnish insurance companies or their representatives information concerning my (my dependents) illness and treatments and I hereby assign to Ibn Sina Foundation all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered or unpaid by insurance. I have read and understand the financial policy of Ibn Sina Foundation and accept the terms.

POLÍTICA FINANCIERA: Todos los servicios profesionales prestados por la Fundación Ibn Sina se cobran al paciente. Todos los servicios prestados a usted como paciente de la Fundación Ibn Sina son pagaderos en el momento del servicio y son responsabilidad exclusiva de usted "el paciente" y/o garante de Menor (sus hijos). Por la presente autorizo a la Fundación Ibn Sina a proporcionar a las compañías de seguros o a sus representantes información sobre mis enfermedades y tratamientos y por este medio asigno a la Fundación Ibn Sina todos los pagosporserviciosmédicosprestados a mí oa misdependientes. Entiendoque soy responsable de cualquier cantidad no cubierta o no pagada por el seguro. He leido y entiendo la politica financiera de la fundacion Ibn Sina y acepto los terminos.

Alternative Contacts Authorization: In my absence or for the benefit of gaining medical advice on my behalf, I authorize the following person(s) to gain patient health information for / with me.

CONTACTOS ALTERNATIVOS AUTORIZACIÓN: En mi ausencia o en beneficio de obtener asesoramiento médico en mi nombre, autorizo a las siguientes personas a obtener información de salud del paciente para o conmigo.

Name	**Relationship**	**Telephone #**

EMAIL COMMUNICATION: If at any time I provide an email address at which I may be contacted, I consent to receive appointment reminders and other healthcare communications, promotions, and information at that email from the Ibn Sina Foundation. I also understand that this disclosure will exclusively be used by Ibn Sina Foundation.

CONSENTIMIENTO PARA LA COMUNICACIÓN DE CORREO ELECTRÓNICO: Si en algún momento proporciono un correo electrónico al cual puedo ser contactado, consiento en recibir recordatorios de citas y otras comunicaciones, promociones e información de atención médica en ese correo electrónico de la Fundación Ibn Sina. También entiendo que esta divulgación será utilizada exclusivamente por la Fundación Ibn Sina.

SIGNATURE:

I hereby state that to the best of my knowledge, the above information is current, correct, and true. I understand that it is my responsibility to inform Ibn Sina Foundation if I, or my minor child, have changes in any of the information provided above.

Por la presente declaro que yo entiendo que la información reciente es actual y correcta y verdadera. Entiendo que es mi responsabilidad informar a la Fundación Ibn Sina si yo, o mi hijo menor, tenemos cambios en cualquiera de la información proporcionada anteriormente.

_____ _____ _____/_____/_____

Patient/ Parent / Authorized **Signature**/ Firma autorizad | Print Name/ Nombre impreso | Date/ Fecha

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GENERAL CONSENT FORM IBN SINA FOUNDATION

CONSENT FOR TREATMENT: I, the undersigned, have voluntarily presented to Ibn Sina Foundation for medical/or dental evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or his or her designee(s) to provide diagnostic and therapeutic treatment, which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment(s).

HIV CONSENT: I understand that during the time of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. As part of my treatment, it may be requested that I be tested to determine if I have/had previous contact with the HIV, Hepatitis B, and Hepatitis C. This might be done as part of a diagnostic test or for hospital/or clinic infection control reasons. I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker.

RELEASE OF INFORMATION: I hereby authorize the Ibn Sina Foundation to use or disclose my protected health information acquired during my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment as described in the Notice of Privacy Practices. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs. Ibn Sina Foundation may provide vaccination information to the state vaccine registry via electronic integration. I understand that my consent is not needed if the law requires Ibn Sina Foundation to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease and potential bodily harm to myself or others). I understand and acknowledge that Ibn Sina Foundation participates in an electronic medical record exchange program, and that if I seek treatment from other healthcare facilities or providers participating in this exchange program, my health information may be shared between Ibn Sina Foundation and those other facilities or providers for purposes of the delivery of care and services to me. I understand that my medication history will be retrieved for the last 12 months including medications I have filled through my prescription drug plan.

MEDICARE/MEDICAID PATIENTS: I authorize to release medical information about me to the social security administration or its intermediaries for my Medicare/Medicaid, or Medigap claims. I assign the benefits payable for services to Ibn Sina Foundation.

NOTICE OF PRIVACY: HIPPA ACKNOWLEDGMENT: I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain patient rights regarding my protected health information. I understand that I have the right to review Ibn Sina Foundation Notice of Privacy Practices/Patients' Rights and the most recent copy is available upon request. I understand that I may request restrictions be put on the use of my information, and to revoke my consent at a later date. I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, Ibn Sina Foundation may refuse to undertake my care.

TREATMENT BY TRAINEES: I understand that Ibn Sina Foundation takes part in education of medical/dental trainees and as such, services may be performed by individuals selected and deemed qualified by the attending physicians. Further, treatment and medical records may be reviewed by approved student and attending physicians for teaching, studies, and research purposes. Information identifying patients will not be published without prior patient consent. I authorize residents /students to observe, cooperate, and participate in my care.

GHH Consent: Ibn Sina Foundation participates in Greater Houston Healthconnect (GHH), a non-profit organization that provides a secured electronic network for Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payers of health claims such as health insurers to share your protected health information. By signing this Authorization, you agree that GHH and its current and future participants may use and disclose your protected health information electronically through GHH for the limited purposes of treatment, payment and health care operations. This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to any healthcare provider who participates in GHH.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I also understand that by refusing to sign this complete consent or revoking this consent, this organization may refuse to treat me.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY.

_____ _____ _____

SIGNATURE (Patient or Legal Guardian/Representative) **Relationship** to Patient if Signed by another party **DATE**

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Insurance Information

Primary Insurance Company	Member ID #	Group #	Effective Date: _____/_____/_____
Policy Holders Full Name:	DOB: ___/____/_____	Sex: ☐Male ☐Female ☐Other _____	Social Security #
Claims Address (if different):		Phone #	Patients Relationship to Policy Holder:
Secondary Insurance Company:	Member ID #	Group #	Effective Date: _____/_____/_____
Policy Holders Full Name:	DOB: ___/____/_____	Sex: ☐Male ☐Female ☐Other _____	Social Security #
Claims Address (if different):		Phone #	Patients Relationship to Policy Holder:
Please provide your insurance card and photo ID to the receptionist. Thank you.			

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to the provider, as per my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 60 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. Further, I as a parent / legal guardian give consent for treatment for this, and future services rendered to the minor covered under m y insurance plan.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and ask any questions.

Responsible Person/Patient Signature: _____ Date: _____

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Authorization to Consent to Treatment of Minor

CHILD INFORMATION				
First Name/Nombre:	Last Name/ Apellido	MI	DOB: __/__/____ Fecha de Nacimiento	Sex: □ Male □ Female □ Other _____
Address/Direccion:	City/Ciudad:	State/Estado:	Zip Code/Codigo Postal:	County/Condado:
Parent / Guardian Information				
Name of Parent	Relationship	Phone #/Numero de cellular		
Pharmacy Information	Name of pharmacy	Phone #	Address	

CONSENT

A minor is an individual who is under 18 years of age who is not and has been married or had the disabilities of minority not been removed by the court

I , _____ , am the [**Parent/Legal Guardian**] of the minor child above, and have the power to consent to medical or dental treatment for [Him/Her]. I hereby voluntarily consent to authorize the medical staff and dental staff of Ibn Sina Foundation to provide health care services to the above minor. The physical health care services may include, but are not limited to, routine laboratory work, x-ray examinations/other imaging studies, anesthetic treatment, administration of medication, as well as procedures and treatments prescribed by the medical or dental staff. The preventative health strategies could include school immunizations, flu shots, and virus testing (strep throat, COVID-19, flu). No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

Please indicate your consent for each service category below by circling "yes" or "no":

(1) Physical health care (lab work, x-ray/imaging studies, administration of meds etc.)	Yes	No
(2) Dental health care (routine exam, cleaning, x-rays, cavity fillings)	Yes	No
(3) Health education (healthy life-style, diet, exercise, disease education)	Yes	No
(4) Preventive health strategies (school immunizations, vaccines, flu shots, virus testing)	Yes	No

I understand that this consent is valid and remains in effect as long as the minor is a patient of the clinic and I state that I have sufficient information, capacity, and authority to give this consent.

Consent to Treat a Minor Child accompanied by an adult other than the child's parent or legal guardian

I, hereby delegate authority to consent to perform medical/dental treatment as per the statements above when accompanied by the following named adult persons over the age of 18:

_____	_____	_____
Print Name of Adult Care Giver	Relationship	Time Period Permission Given

(**Grandparent, Aunt, Uncle, Sister, Brother, Family Friend**)

_____	_____	_____
PRINT NAME (Parent or Legal Guardian)	SIGNATURE (Parent or Legal Guardian)	DATE
_____	_____	_____
PRINT NAME (WITNESS)	SIGNATURE (WITNESS)	DATE