DATE: _____

CONFIDENTIAL

LEE FAMILY PRACTICE ASSOCIATES, P.A.

REGISTRATION INFORMATION

PLEASE PRINT

☐ NEW PATIENT

☐ RETURNING PATIENT

PATIENT INFORMATION

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

DOB: _____ **SSN:** _____-_____-_____

(CIRCLE ONE) SEX: *M / F* **MARITAL STATUS:** *SINGLE / MARRIED / DIVORCE / SEPERATED / WIDOWED*

ADDRESS: _____

STREET **CITY** **STATE** **ZIP**

EMAIL: _____

HOME PHONE: _____ **CELL PHONE:** _____

PARENT/GUARDIAN: _____ **PHONE:** _____

PHARMACY *(THIS IS WHERE WE WILL SEND YOUR PRESCRIPTIONS ELECTRONICALLY)*

PREFERRED PHARMACY: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE: _____

EMPLOYMENT INFORMATION

EMPLOYER: _____ **OCCUPATION:** _____

BUSINESS ADDRESS: _____

WORK PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

MEMBER ID: _____ **GROUP #**_____

POLICY HOLDER: _____ **POLICY HOLDER DOB:** _____

SECONDARY INSURANCE COMPANY: _____

MEMBER ID: _____ **GROUP #**_____

POLICY HOLDER: _____ **POLICY HOLDER DOB:** _____

REQUIRED BY HIPPA

IN CASE OF EMERGENCY, WHO SHOULD WE NOTIFY?

NAME: _____ **RELATIONSHIP:** _____

PHONE NUMBER: _____

☐ *I DO NOT WISH TO PROVIDE AN EMERGENCY CONTACT*

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have been presented with the Notice of Privacy Practices by the front desk receptionist for Lee Family Practice, P.A. and Dr. William O. Lee, detailing how my information may be used and disclosed as permit under federal and state law. A copy is available upon request.

SIGNATURE: _____ **DATE:** _____

(If not signed by patient please fill out the next section)

REPRESENTATIVE SIGNATURE: _____ **DATE:** _____
RELATION TO PATIENT: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I further expressly, agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ **hereby authorize** _____**Lee Family Practice P. A.**_____
(NAME OF INSURED)

To pay and hereby assign directly to Lee Family Practice and/or Dr. William O. Lee all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Lee Family Practice and/or Dr. William O. Lee will be credited to my account, in accordance with the above said assignment.

Signature: _____ **Date:** _____
(SIGNATURE OF SUBSCRIBER)

LEE FAMILY PRACTICE & ASSOCIATES

4 OAKTREE STREET – FRIENDSWOOD, TX 77546

PHONE: (281) 482 – 5551 FAX: (281) 482 – 0995

Patient Portal Consent Form

The Lee Family Practice Patient Portal is a secure online source of confidential medical information for patient. If you would like access to your medical records via the Patient Portal, please complete this form. If you would like to decline access to the Patient Portal, please check the appropriate box below and sign.

Patient name: _____

DOB: _____ **Last 4 Digits of SSN:** _____

Secure Email Address: _____

I agree to the following:

1. I will abide by all terms and conditions of the Lee Family Practice Patient Portal.
2. Lee Family Practice is not responsible for any breach of information caused by patient misuse.
3. I understand that my activities within the Patient Portal will become part of my medical record.

I understand the following:

1. Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.
2. All communication is sent to the nursing staff, not directly to the provide. You will receive a response within 24-48 hours.
3. The Patient Portal is NOT a substitute for office visits with your provide and prescription requests for medications not currently being prescribed will NOT be honored. I acknowledge that I have read and fully understand this consent form and the policies and procedures regarding the Patient Portal.

☐ I choose **NOT** to participate in Patient Portal at this time because:

☐ *I do not have an E-mail address*

☐ *I do not wish to share my E-mail address*

☐ *Other* _____

SIGNATURE: _____ **DATE:** _____

(If not signed by patient please fill out the next section)

REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

RELATION TO PATIENT: _____

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Lee Family Practice. When you schedule an appointment with Lee Family Practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Effective February 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least a 24-hour notice** will be considered a No Show and charged a **$25.00 fee.**

Same Day/Acute "No Shows"
Any patient who fails to keep a same day or an acute appointment, and does not cancel appointment with appropriate notice, is counted and managed as other "No Show"

The fee is charged to the patient, **NOT** the insurance company, and is **due at the time of the patient's next office visit.**

As a courtesy, we make reminder calls for appointments. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. You may contact Lee Family Practice 24 hours a day, 7 days a week at the number below. Should it be after regular business hours you may leave a message.

You can contact our office at (281) 482-5551.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____

Signature (Parent/Legal Guardian) Relationship to Patient

_____

Printed Name Date