Alamo Heights
PRIMARY CARE PHYSICIANS

250 E. Basse Rd., Suite 208
San Antonio, TX 78209
210-226-2424 (O) 210-226-6567 (F)
AlamoHeightsPrimaryCarePhysicians.com

Thank you for choosing Alamo Heights Primary Care Physicians.

To help expedite your check-in, please complete our New Patient Packet before your appointment.

Please bring to your appointment:

- **New Patient Packet completed**
- **New Patient Questionnaire completed**
- **Insurance Cards (primary and secondary)**
- **All medication bottles**

Dr. Jay M. Hoelscher and his team would like to ensure your experience is a pleasant one. We offer something different from other practices. As a smaller individual practice that is not owned by a large corporation or hospital system, we offer the advantage of more personalized care while still offering all the benefits including an electronic record system and secure online access to your health records & test results. We also offer TELEMEDICINE for those insurances that participate, so you can save on travel and wait times. TELEMEDICINE is great for working individuals, students, homebound patients and travelers.

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NAME:_____DOB:_____

MEDICAL RELEASE AUTHORIZATION

_____
Name of Patient (Please Print) Date of Birth

_____
Street Address City, State, Zip Phone

_____
Social Security #

I hereby authorize (Please Print Doctors name and information)
_____
_____
_____

To release to:
Jay M. Hoelscher M.D
250 E. Basse Rd Suite 208
210-226-2424 O, 210-226-6567 F

I consent to release all the medical information regarding my treatment or hospitalization from my:

- General hospitalization or outpatient care
- Drug and alcohol treatment care
- Emergency room visit
- Psychiatric care
- Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

***requires special consent**

I am requesting the following information from my records (check all that apply):

- Complete Health Record(s)
- Abstract of record (includes: History & Physical, Operative Report, Laboratory Report, Radiology Reports, Consultations, Discharge summaries, and other significant findings
- Labs
- X-rays

I permit this confidential information to be released for the following purpose:

- Continuing medical treatment

The date, extent or condition upon which this authorization expires is 90 days not to exceed 24 months (except for research purposes, state **"NONE"** for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below. I understand that information 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 I hereby authorize the release of all necessary medical records to Alamo Heights Primary Care Physicians. Please forward as soon as possible

_____ _____

Patient Name: _____

Patient Signature: _____Date:_____

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NAME:_____DOB:_____

Patient Consent

I hereby give my consent for the office of Jay M. Hoelscher and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

_____ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials)** I understand that as part of my healthcare, Alamo Heights Primary Care Physicians. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among the many health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify that services billed were actually provided, and
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

_____ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

• Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

• If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

• Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

If I do not sign this consent, or later revoke it, the office of Jay M. Hoelscher and affiliated providers may decline to provide treatment to me.

Patient Name: _____

Patient Signature: _____Date:_____

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Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

You voluntarily request Alamo Heights Primary Care Physicians and other physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____

Patient Signature/ Personal Representative Date

_____

Printed Patient Name/ Personal Representative

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Disclosures and Emergency Contact Information

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below: (Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.)

Name:_____ Relationship:_____

Contact Number:_____

_____No one to disclose my information out to (check)

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information**.** If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below). *The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).*

E-mail: _____

Cell: _____

Patient Name: _____

Patient Signature: _____Date:_____

Revocation

I hereby revoke my request for future communications via email and/or text.

_____*I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*

_____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*

NOTE: This revocation only applies to communications from this Practice only.

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Financial Responsibility

Alamo Heights Primary Care Physicians submit claims as a curtesy for you.

- Your insurance policy is a contract between you, your employer and the insurance company. WE ARE NOT a party to that contract. Our relationship is with you. We cannot become involved in the disputes between you and your insurer regarding deductibles, copays, covered charges, secondary insurances, and Usual and customary charges
- You are responsible for providing all needed verbal/written information prior to your scheduled office visit to help assist the insurance claim process. This information is used to verify your health insurance status and authorized provider assigned to you.
- Should your insurance coverage be denied and/or Dr. HOELSCHER not be your authorized provider, please be aware that you are responsible for full payment. You will be responsible for paying for your office visit "Fee for Service" in full at the time of medical service. If the insurance does not pay with in 30 days it is your responsibility to contact your insurer to expedite payment. If your insurer does not pay with in 60 days, you will be responsible for payment. We will not resubmit claims after 60 days.
- You will be responsible for following up with your insurance carrier for reimbursement if applicable.
- If you claim gets denied for any reason including "not medically necessary" or they don't like a diagnosis code, we will only appeal the claim one time with in the 60 days from your date of service. Then it is your responsibility to pay our office and seek reimbursement through the insurance you have chosen.
- You understand and agree to pay a $45.00 fee for every missed appointment if that appointment is not cancelled with at least 24 hours' notice to the practice.
- LAB FEES: Your lab billing is separate from our physicians billing and you may get a bill from the lab. We do not submit any claims for labs.

I understand if I have an unpaid balance to Alamo Heights Primary Care Physicians and do not make satisfactory payments my account will be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all cost and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.

In order for Alamo Heights Primary Care Physicians or their external collection agency to service my account, and where not prohibited by applicable law, I agree that the collection agency and Alamo Heights Primary Care Physicians are authorized to contact me by telephone, text messages, and emails where any fees and data rates may apply, of methods of contact. This may include pre-recorded voice messages.

Please fill out the information below. Your signature will indicate that you have read, understood, and agree with the Office policy and missed appointment policy as stated in our Patient Health Contract. If you would like a copy of the office policy please request the copy before you leave from your appointment.

_____ _____

Signature of Patient Date

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It is our policy to collect debit/credit card information to have on file in the event of a missed appointment without proper advance notice. Your information will be kept private and will only be used if you incur a Missed Appointment Fee.

Credit Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Cardholder Name: _____
Credit Card Number:_____
Expiration Date: _____/_____/_____ Zipcode: _____

Insurance information:

Policy Holders Name:_____
Policy Holders Dare Of Birth:_____

Primary Insurance:_____
Member ID:_____
Group Number:_____[_____

Secondary Insurance:_____
Member ID:_____
Group Number:_____

Pharmacy:_____
Pharmacy Address:_____
Pharmacy Phone Number:_____

Prefered Lab:_____
Prefered Imaging:_____

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OFFICE POLICIES

To properly serve you, we have developed our policies below to promote an organized treatment experience. Please review this very important information below and again, thank you for being our patient.

Your first visit with Dr. Hoelscher is to establish care as a new patient. At this appointment we review your medical history and medications, begin the process of gathering previous medical records, address acute concerns, and provide medication refills when needed. The front desk staff will also collect the necessary billing information and ask you to read and sign the new patient packet. The doctor will address specific areas of concerns with your health that you may have during your first visit as well. Dr. Hoelscher then has the knowledge to order the appropriate labs and can make a plan of care. AFTER the initial visit to establish care, an "Annual Physical" can be scheduled. When possible, labs will be ordered BEFORE the annual visit so the results can be discussed IN PERSON to allow the opportunity to ask questions and have direct interaction with the doctor. Dr. Hoelscher feels the face-to-face discussion of results is the best way to care for you because it provides the best communication. Please understand the services provided during the first visit to establish care are unique. They are NOT intended to be your "annual visit" and cannot be billed as such.

(PLEASE INITIAL BESIDE EACH SECTION INDICATING YOUR UNDERSTANDING AND ACCEPTABLE OF OUR POLICIES.)

_____ In order to better serve you, we ask that you arrive 15 minutes before your scheduled time. If you are late for your appointment, the physician will not be able to address all medical issues during your visit and may even request that you reschedule for another time. We make every effort to see patients in a timely fashion and your prompt arrival and avoidance of missed appointments helps us schedule appropriately to accomplish this.

_____Please provide us with all necessary insurance information and bring the card and a valid form of picture identification with you to each and every visit. Inform us of any changes in your health insurance status or demographic and contact information within 7 days of your visit, as we need time to verify your coverage. Late notification of this may result in a rescheduled appointment.

_____If we DO participate with your insurance plan**, your co-payment as well as any insurance deductible amount that is your responsibility will be collected before being seen by the physician**. This will include any past due payments. There may be additional charges over and above your co-payment due at the time of your appointment depending on your specific insurance benefits package.

_____ If we DO NOT participate in your insurance plan or you have no insurance, full payment of all charges is expected at the time of your appointment prior to seeing the physician.

_____Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. It is very important that you understand the provisions of your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, their policyholder. Reduction or rejection of your claim by your insurance does not relieve you of your financial obligation.

_____ If you need specialized equipment through a DME company, you will be required to call your insurance to see what company they use so we can submit the request.

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_____ Referrals can take up to 14 business days to complete.

_____ Alamo Heights Primary Care Physicians has a no tolerance policy for verbal abuse from patients or family members/caretakers of patients. We understand the medical field can be very difficult but proper communication is needed for care. If there are any issues please contact the manager through the private patient portal.

_____ We accept Mastercard, Visa, Discover, a local personal check with ID, and cash. A service fee of $35 will be assessed for all returned checks to cover bank charges.

_____ Please bring to your appointment all the actual bottles or boxes of medications, vitamins, or supplements (prescription or over-the-counter) that you take regularly or an updated written list of your active medications and dosages you are actually taking. If you are a diabetic patient, please bring a log of your glucose readings to each visit.

_____Prescriptions are a high priority for us. **The fastest way to get your refill is by calling your pharmacist** and giving them your prescription number located on the label on the bottle, or by utilizing the automated refill system many pharmacies have in place. When no further refills are available, continued refill authorization **will require an office visit** for the chronic condition within the past 6 months. (acute visits do not comply for this refill)

_____Narcotic, anti-anxiety medication, and any other controlled substance refills will require you to be seen each time for a written prescription in order to comply with the standard of care for medical documentation as to the reason for the ongoing need for treatment, We will refer to a specialist if this is needed for long term treatment. A Urine toxicology screening will be required. Please note **ALAMO HEIGHTS PRIMARY CARE PHYSICIANS WILL NOT PRESCRIBE CONTROLLED MEDICATIONS ON YOUR FIRST VISIT**. Finally, please allow for at least 3 business days for us to process your refill authorization to ensure there is no interruption in your care.

_____ If your prescription requires a prior authorization, please allow 72 hours for this to be complete. We are at the mercy of your insurance to respond to our request. If the authorization was denied it will be your responsibility to call your insurance to see what is on your formulary and what medication is in your budget.

_____We will give you a courtesy call 2 business days prior to your appointment as a reminder. Missed patient appointments create problems in scheduling that affect not only you but also the rest of the patients in the practice. We realize there may be unforeseen circumstances that lead to a need to reschedule an appointment. In such cases we request to be notified of your cancellation 24 hours prior to your appointment time. If insufficient or no notice is given, a cancellation fee in the amount of $45 will be for your appointment. If you have 4 missed appointments without notification (“no shows”) in a 2-year period, we will unfortunately need to end the physician-patient relationship and you will be terminated from the practice.

_____Paperwork including letters, insurance forms, FMLA papers, and other forms needing to be completed by Dr. Hoelscher take significant time. Depending on how many pages need to be completed the cost will ranges from $60-150.00 per form. Please allow for 7 business days for these to be done. An additional $50 fee will be assessed for forms presented in less than the required time allotment. Payment will be due at the time the forms are presented for completion.

_____Dr. Hoelscher will schedule a follow-up appointment with you to discuss in person the results of labs and Xrays he has ordered. He feels this is the absolute best way to be able to answer your questions regarding the results and formulate a plan of care. Once he has had the opportunity to consult with you about the results, they will be posted on your private patient portal for you to reference as you desire. We encourage each patient to sign up for access to this

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portal through our website at www.AlamoHeightsPrimaryCarePhysicians.com. If you have any questions regarding your appointment, please feel free to contact our office at (210) 226-2424. Our dedicated staff will be happy to assist you.

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Alamo Heights Primary Care Physicians at 210-226-2424.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____ _____

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NAME:_____DOB:_____

Witness Signature Date

INSURANCE COVERAGE WAIVER/ CASH PAY

I understand that my eligibility for coverage by _____ (name of insurance company) **cannot be confirmed** at this time. I wish to receive medical services from Jay M. Hoelscher, M.D. If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided

*Signature of Patient/Legal Guardian*_____*Date*_____

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