Russell C. Vanbiber III, M.D.

2500 Fondren Rd. Ste 255 Houston, TX 77063
Phone: 832-769-3313 Fax: 832-769-3307

Patient Registration Information

Please **READ AND** complete **ALL** sections below!

PATIENT'S PERSONAL INFORMATION

Name: _____ _____
Last name First Name

Date of Birth: _____ / _____ /_____Social Security #: _____ -_____-_____ Email:_____@_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female **Preferred Language:** ☐ English ☐ Spanish ☐ Other _____

Ethnicity: ☐ Hispanic/Latino☐ Not Hispanic/Latino ☐ Other_____ **Race**: ☐Caucasian ☐ Asian ☐ African American/Black ☐ Hispanic ☐ Other_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION Relationship to Patient: ☐Self ☐ Spouse ☐ Child ☐ Other_____

Name: _____ _____ _____
Last name First name Initial

Date of Birth: _____ / _____ /_____Social Security #: _____ -_____-_____Email:_____@_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

REFERRAL INFORMATION ***How were you referred to our office? Zoc Docs Internet Search Patient***

If referred by Patient: Name:_____

EMERGENCY CONTACT Relationship to Patient: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

PHARMACY INFORMATION Drug Allergies: _____ Food Allergies: _____

Name: _____ Phone: (_____) _____ Fax: (_____) _____

Address: _____City:_____ State: _____Zip:_____

All Prescription refill requests are subject to a 48hr time notification. Weekend and holiday refills will be during normal business hours.

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I, herby give lifetime authorization for payment of insurance benefits to be made directly to Dr. Vanbiber and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and to appeal all outstanding claims until payment is received. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ **Date:** _____

Russell C. Vanbiber III, M.D.
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Effective January 1, 2021

FOR ALL PATIENTS

REMINDER TO ALL PATIENTS THAT CANCEL THEIR APPOINTMENT WITHIN 24hrs OR DO NOT SHOW THERE IS A $35.00 CHARGE. AFTER THE 2ND NO SHOW YOU WILL BE RESPONSIBLE FOR PAYING THE FULL PRICE FOR THE VISIT.

All co-pay's, deductibles and co-insurance are due at time of visit.

Forms to be completed by the office or doctor are $35.00

If your insurance company requires a **Prior Authorization** for any medication there will be a charge of $25.00 due by the patient before it is initiated. This is not a guarantee that it will be approved.

ALL PATIENTS ON CONTROLLED MEDICATIONS **prescription refill pick-ups will now be a $15.00 FEE EACH SCRIPT.**

ALL PATIENTS ON CONTROLLED MEDICATIONS **are required to see the doctor every other month and required to do a drug screen at every visit.**
Drug Screens are done in office and not billed to insurance the charge is $25.00

NON INSURED PATIENTS-"no insurance"

Self Pay visits for Controlled prescriptions are now $145.00 for new patients.

Self Pay visits for Controlled prescriptions are now $110.00 for existing patients.

Office visits for Testosterone prescriptions require the following labs (CBC, CMP, Testosterone and Estradiol).
And a visit is required for all testosterone refills

Self Pay visit for all other issues are $110.00 for new patients.

Self Pay visit for all other issues are $90.00 for establish patients.

Print Name	Signature	Date

Office, Financial and HIPAA Policies Acknowledgement

Welcome to the office of Dr. Russell C. Vanbiber. Our goal is to provide the best quality of care for our Patients. The Staff or Dr. Vanbiber will not perform any services that they do not feel are reasonable or necessary for your wellbeing. We will strive to make your visits to our office as comfortable as possible. Please read and sign these policies prior to your treatment so that you will have a better understanding of our office policies.

Payment in Full is due at the time services are rendered: For your convenience we accept cash, check, and credit cards (MasterCard, Visa, American Express, and Discover) with the name of the card holder present. All non-cash transactions and/or services that are to be filed to insurance require a legal form of picture identification (Drivers license, state identification card, passport) are scanned into our EHR system and your social security number. The office will file your claim to those insurance companies with whom we have current contracts.
There is a $50.00 charge on all Returned Checks and we do not accept post-dated checks.

Insurance Contracts within the contract obligate to collect any and all co-pays, deductible or co-insurance amounts from you. This is done prior to the visit & for any services rendered that day. As a courtesy, this office attempts to verify your insurance benefits prior to any services you may receive. The information we receive is not a guarantee of coverage or payment. You are ultimately responsible for knowing your plan benefits and requirements and therefore responsible for any and all co-pays, deductibles, co-insurance and non-covered services as identified on the explanation of benefits we receive from your insurance plan.

It is your responsibility to notify our office of any change in insurance coverage. To facilitate this process it is required at every visit that patients complete and sign the sign-in form. This helps to ensure that our office updates your information at every visit. Failure to provide current insurance information at the time of service may result in you being held responsible for the full amount of the charges due to the claims filing deadlines required by your insurance which are typically 90-days or less.

Many insurance plans require prior-authorization for certain tests. These must be obtained prior to treatment. Without the proper authorization, your insurance may refuse to pay. As a result you will be responsible for all charges. It is the patient's responsibility to obtain referrals for office visits, and for specialists or other test and or medication prior authorizations.

Minors (Children under the age of 18) must be accompanied by an adult. The accompanying parent or guardian must assume financial responsibility.

For your convenience and safety, **Prescriptions** are issued during office hours only. Refill request have a 48 hour turn around. If you take medications for a chronic condition you are required to see the physician on a regular basis. **It is your responsibility to plan ahead so that you do not run out of your medications. If your insurance company requires a Prior Authorization for any medications there will be a FEE of $25.00 due by the patient before it is initiated. This is not a guarantee that it will be approved.**
FOR ALL CONTROLLED MEDICATION REFILLS THERE'S A $15.00 FEE FOR EACH PRESCRIPTION.*
Drug Screens are required for all patients on controlled prescriptions the fee is $25.00. We do not bill insurance.

You will be assessed a $35.00 No-show fee for any appointment not cancelled at least 24 hours prior to scheduled appointment.
This office has established an email policy to better serve our patients. If you provide us with your Email address, you are giving us permission to email your test results and/or other personal health information. Emails sent from this office are a one-way communication and return emails will not be accepted. You will need to contact our office or schedule and an appointment if you have questions about any information contained in the email. Our office is dedicated to keeping your medical record information confidential; third parties may have access to email messages despite out best efforts. You should be aware that some companies consider email corporate property and your messages may be monitored if you communicate from work. This office is not responsible for information loss or delay or breached in confidentiality that are due to technical factors beyond this office's control.

If you have **Lab Test or X-rays** Please allow **15 days** from the date the test were performed to phone our office for results. Normally within this time frame we have notified you of the results. There are times when the mailed notice may ask you to make an appointment. Please do not be alarmed, this typically means that the provider wants to speak to you in person for clarification or educational reasons. Be assured that if your results are of an urgent nature the physician or nurse will call you immediately to discuss or give you further directions.

As a professional courtesy we will fax or email your medical records to other physicians with a signed authorization to release health information. Medical records are available to the patient with a signed authorization to release health information and a charge of $25 for first 20 pages and .50 cents each page after that. Medical Records requested by insurance companies, attorneys, social security must be requested by those entities.
For all FMLA, Employee forms and Disability forms, there is a $35 charge up to 3 pages each time.

Patient Signature: _____ Date: _____

HIPPAA DISCLOSURE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in your medical record at our office, or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by our office to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly (b) Obtain payment from third-party payers (c) conduct normal healthcare operations such as quality assessments and physician certifications (d) Notification of educational events specific to my medical condition through our office or networking organizations.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from our office. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

RELEASE OF INFORMATION

AUTHORIZED PREPRESENTATIVE(S):
Please list family or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and healthcare operations).

☐ **DECLINE RELEASE OF INFORMATION (CHECK)**

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Signature: _____**Date:** _____
Patient/Parent/Guardian

PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:**____/____/____

Reason for Today's visit: _____

Past Medical History

Previous Physician's Name: _____ Date of last exam: _____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for?_____

_____

Have you every had a Tetanus shot? ☐Yes ☐No If yes, date: _____

Have you every been vaccinated for Whooping cough *(Pertussis)*? ☐Yes ☐No If yes,date: _____

Have you ever been tested for hepatitis A, B, or C? ☐Yes ☐No Which hepatitis virus? _____

Have you ever been vaccinated for hepatitis B? ☐Yes ☐No If yes, date series completed: _____

Have you ever been vaccinated for hepatitis A? ☐Yes ☐No If yes, date series completed: _____

Last Tuberculosis (TB) Screening? _____ Results of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _____ Result of x-ray: ☐Positive ☐Negative

Which of the following conditions have you been treated? Current and past. (please check)

☐ ADD	☐ Eye disorder/Glaucoma	☐ Kidney/Bladder	☐ Seasonal allergies
☐ ADHD	☐ Fatigue	☐ Liver Problems	☐ Seizures
☐ Anemia or blood problems	☐ Fibromyalgia	☐ Low blood pressure	☐ Shortness of breath
☐ Anxiety	☐ Gout	☐ Lung problems/cough	☐ Sinus Problems
☐ Arthritis	☐ Headaches/Migraines	☐ Memory Loss	☐ Staph Infection
☐ Asthma	☐ Heart Disease Murmur/Angina	☐ Neurological problem	☐ STD:_____
☐ Cancer: _____*(type)*	☐ Heartburn (reflux)	☐ Parkinson's Disease	☐ Stroke
☐ COPD	☐ Hepatitis _____ ***(indicate A.B,C if applicable)***	☐ Phobias:_____ (list)	☐ Swollen Ankles
☐ Crohn's Disease	☐ High blood pressure	☐ Pneumonia	☐ Tonsillitis
☐ Depression	☐ High Cholesterol	☐ Polio	☐ Ulcer/Colitis
☐ Diabetes Type___ ***(Indicate type I, II)***	☐ HIV/Ads	☐ Prostate	☐ Ulcers
☐ Diverticulitis	☐ Hyperthyroid	☐ Psychiatric Care	☐ UTI
☐ Ear Problems	☐ Hypothyroid	☐ PTSD *(Post traumatic stress disorder)*	☐ Vertigo
☐ Eating disorder	☐ Joint and muscle pain	☐ Rheumatoid arthritis	☐ **No past/current issues**

Please describe any current or past medical treatment not listed above: _____

_____

PATIENT HISTORY FORM

Past Surgical History: (Please list any past surgeries and dates)

☐ No Surgeries (Including dental)

Date	Surgery type	Reason	Surgeon Name
Example: 01/01/2012	*Hernia Repair*	*Hiatal Hernia*	*John Smith, M.D.*

Allergies:

Allergic to penicillin? ☐Yes ☐No If yes, describe what occurs? _____

Allergic to Sulfa? ☐Yes ☐No If yes, describe what occurs? _____

Please list drug allergies: _____

Describe symptoms/side effects: _____

Medications: Taken over the past 45 days

List medications including prescription, OTC, supplements, vitamins, energy drinks.
☐**NOT TAKING ANY MEDICATIONS OR VITAMINS/SUPPLEMENTS/ENERGY DRINKS**

Medication	Mg	How many times a day	Reason for medication	When did you begin taking it?
Example: Aspirin	*81mg*	*Once a day*	*Preventative*	*01/01/2012*

Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If yes, how long: _____
How many packs per day? _____ If no, when did you quit? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If yes, How many drinks per day?_____

If no, have you in the past? ☐Yes ☐No When did you quit? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day?_____

PATIENT HISTORY FORM

Family History

	Living		Age (or age at death)	List serious illness
Mother	☐Yes	☐No	_____	_____
Father	☐Yes	☐No	_____	_____
Sister	☐Yes	☐No	_____	_____
	☐Yes	☐No	_____	_____
	☐Yes	☐No	_____	_____
Brother	☐Yes	☐No	_____	_____
	☐Yes	☐No	_____	_____
	☐Yes	☐No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart Disease	_____
High Blood Pressure	_____
HIV disease/AIDS	_____
Mental Illness/Depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History

How many times have you been pregnant? _____
Have you had an abnormal Pap Smear? ☐Yes ☐No
Date of last Pap Smear: _____
Date of last mammogram? _____ Mammogram results:_____
Have you ever had a bone density? ☐Yes ☐No Bone Density results: _____

Male:

☐Yes ☐No Has your interest in sex (libido) declined
☐Yes ☐No Have you ever had an abnormal PSA test exam?
☐Yes ☐No Declined energy level or stamina?
☐Yes ☐No Spontaneous erections?(without medication)

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, accurate, and without omissions.

Patient/Legal Guardian Signature: _____ Date: _____