

Patient Registration Sheet (PLEASE PRINT)

If you were referred to our office by another Doctor, please give us the name, address and phone number. We will send this doctor a thank you letter regarding your visit:

Doctor's Name: _____ (MD, DO, DC)
Phone # _____ Address _____

- Today's Date: _____ Social Security #: _____ - _____ - _____ Age: _____
- **PATIENT's NAME:** _____ Date of Birth: ____/____/____
- Address: _____ City _____ ZIP _____
- Cell #: _____ Work#: _____ E-mail: _____
- Marital Status: (M/S/D/W) Circle One (M/F) Employer: _____
- Preferred Pharmacy: _____ Phone#: _____
- Responsible Party (for insurance purposes) _____ DOB: _____

PLEASE INDICATE AUTHORIZED CONTACT METHODS BELOW:

- Text Email Voice Mail Patient Portal

EMERGENCY CONTACT:

- Name _____ Relationship _____ Phone # _____

Due to insurances having multiple plans and policies, our office does our best to determine whether or not you may require an authorization or referral prior to your visit. **However**, it is **YOUR RESPONSIBILITY** to know whether or not **YOUR INSURANCE requires an authorization or referral to see Dr. Schauder**. If your insurance requires the authorization or referral and **YOU DO NOT** bring this with you to your visit **OR** if your insurance requires a referral/authorization and none is obtained you will be responsible for payment in full. **PLEASE NOTE:** Dr. Schauder is not a workers compensation provider and we cannot bill your healthcare insurance for a work-related injury. You will be responsible for payment at the time of service. It is considered fraud for us bill your private insurance for a work-related injury.

Please Initial Here _____

CONSENT FOR TREATMENT:

This consent provides us with your permission to perform reasonable and necessary medical examination, testing and treatment for the condition/conditions which has brought you to seek care at the practice. By signing below, you are indicating that (1) you consent to treatment at this office or any other satellite; (2) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain fully effective until it is revoked in writing. 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 your treatment, we encourage you to ask questions. You have the right to discontinue services at any time.

AUTHORIZATION FOR PAYMENT:

I hereby authorize Dr. Keith Schauder or his agent to furnish any medical information to my medical representative, attorney, employer or other provider of service. I also agree that all payments made by insurance may be directed toward my physician's office. I understand I am ultimately responsible for any balance on my account and payment in full is expected at the time of service.

YOUR signature below confirms your agreement with the office policies above

PATIENT SIGNATURE: _____

DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

Please provide us a list of people (**husband, wife, children, other family, friends, attorneys, or other doctors**) we may share your Private Health Information with (**this also includes appointment times**). If you do not want us to speak with anyone please write **NONE**.

Effective December 1, 2017 a new Notice of Privacy Practices is posted in our office and on our website at www.dksmd.com for your review.

Disclosure of personal information to any affiliates will be to the minimum necessary in order to provide you with the utmost privacy and best medical care we are able to provide.

This notice is meant to inform you of how we safeguard your nonpublic personal information. Your trust and confidence are important to us and we strive to maintain your continued trust.

By signing this notice, you are stating that you are aware of our privacy practice, and by filling in the blanks above you are allowing us to disclose information to affiliates that you choose. This notice is effective December 1, 2017 and will remain in effect until revised or revoked.

PATIENT/GUARDIAN SIGNATURE

DATE

WITNESS SIGNATURE

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with the above code, Keith Schauder MD PA strives to provide the most personalized and up to date care for our patients. Dr. Schauder has partnered with several institutions in the area which share in this goal. We are pleased to inform you Dr. Schauder has made investments in Gulf Coast MRI and United Surgery Center. Referrals may be made to these specific facilities to insure our patients receive priority service; however you have the option to choose to go to any facility of your choice. You will not be treated differently by Dr. Schauder if you choose to use another facility other than United Surgery Center or Gulf Coast MRI.

By signing this Disclosure of Physician Ownership you acknowledge you have read and understand the foregoing notice of Dr. Schauder's ownership interests in Gulf Coast MRI and United Surgery Center

Patient/Guardian Signature

Date