12410 Toepperwein Rd
Live Oak, Tx 78233

2339 East. Evans Rd.
San Antonio, Tx 78259

6500 South. Flores St.
San Antonio, Tx 78259

www.hillsideprimarycare.com

Consent for Treatment

I voluntarily consent to treatment and/or related services by Hillside Primary Care which may be advised and recommended by the attending physician. I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for Hillside Primary care to render such emergency treatment and/or transfer myself or my child to a hospital for treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this organization. I understand that i may see a nurse practitioner (NP) or a physician assistant (PA) that is practicing under Dr. Patel's supervision at this practice.

I am aware that I may stop my treatment with Hillside Primary care at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Hillside Primary Care may stop treatment.

I acknowledge that I have received a copy of Hillside Primary care Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by Hillside Primary Care and states my rights with respect to my Protected Health Information (PHI). I understand that Hillside Primary Care has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Hillside Primary care changes this Notice, a revised Notice will be posted in the office waiting area and that I may obtain a current Notice of Privacy Practices at any time from the front desk.

Name: ___________________________________ Date: __________________

Signature: ________________________________

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Patient Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due at The Time of Service Unless Prior Arrangements Are Made. We Accept Cash, Visa, Master Card.

Insurance Participation:
We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated co-payments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of your insurance Cards. Blood lab fee will be charged to your insurance company but in the event of non-coverage test, you will be responsible to pay for tests. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements. I understand that NO REFUNDS WILL BE GIVEN UNDER ANY CIRCUMSTANCE.

Adult patients are responsible to adhere to the above policy which may require full payment at time of service.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. Unless cancelled, at least 24 hours in advance, **our policy is to charge $50.00 fee for appointments not cancelled 24 hours in advance.**

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the "Financial Policy" and agree to abide with the requirements.

Name: ______________________________ Date: ________________

Signature: ____________________________