JAY R. WALTHER, M.D.
PATIENT INFORMATION

Last Name:_____ First Name:_____ M.I._____

Mailing Address: _____ City, State, Zip_____

Employed: Yes or No Home Phone:_____Work Phone:_____Cell:_____

DOB:_____-_____-_____ SEX: M or F SSN:_____Marital Status:_____

Patient Employer: _____Occupation: _____

Race:_____ Ethnicity: Hispanic OR Non-Hispanic Language:_____

Email Address_____

**********MEDICAL INSURANCE INFORMATION**********

(Please give receptionist your insurance card & picture ID to copy)

Primary Insurance: _____ Effective Date: _____

Secondary Insurance: _____ Effective Date: _____

Primary Policy Holder (self/spouse/parent):_____

If policy holder is different than that of Patient, please provide the following information

Policy Holder Name: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____

Employers Phone Number: _____Employers Address:_____

DOB: _____-_____-_____ SSN: _____ DL#_____

In Case of Emergency (relative/friend not living with you)

Name: _____ Phone: _____ Relationship to patient: _____

Name: _____ Phone:_____ Relationship to patient:_____

I understand and agree that I will be responsible for payment of all charges incurred. Jay R. Walther, M.D. request that all office visits be paid at time of service. Co-payments are due before all office visits. We will file secondary insurance when Medicare is the primary insurance.

Patient Signature: _____ Date: _____

If Patient is a Minor: _____ Date: _____

Witness: _____ Date: _____

JAY R. WALTHER, M.D.
PATIENT CONSENT FOR TREATMENT

The following matters are of special concern to patients and their families. Be sure you understand these matters when you indicate your agreement below. If signed by other than the Patient's act and deed.

1. MEDICAL AND SURGICAL CONSENT. The patient, under the medical care of Jay R. Walther, M.D. or his/her designee, recognize the physician's designee's are not liable for any act or omission in following the instructions of said physician. The undersigned consents to physician examinations, laboratory procedures, diagnostic procedures, administration of drugs, intravenous feedings, injections, anesthesia, medical and surgical treatment and other services necessary or beneficial to the patient.

2. TESTING FOR HIV/AIDS AND OTHER INFECTIOUS DISEASES. Texas law authorized a physician to require a patient to be tested for possible exposure to the Human Immunodeficiency Virus (associated with AIDS) and/or to other infectious diseases in the following situations: (1) When the donation of blood, blood products, organs, or tissues in contemplated, (2) When a healthcare worker is accidentally exposed to patient's blood or body fluid such as through a needle stick, or (3) When a medical or surgical procedure is to inform the patient that he/she may be tested without further disclosure if any of the situations occur during the patient's visit to Jay R. Walther, M.D.

3. STUDENTS. It is my understanding that clinic doctors promote their mission of education by having affiliations with several educational institutions. This includes, but is not limited to, training of nursing students, interns and residents. The intent of this association is to allow students the opportunity to gain clinical experience.

4. AGREEMENT. I, the authorized undersigned, hereby give the doctor, nurse practitioners, physician assistants, nurses, technicians and other personnel authority to proceed with diagnosis and treatment. In consideration of the services to be provided. I hereby release and agree to hold said doctor, nurse practitioners, physician assistants, nurses, technicians and other personnel harmless from any and all consequences of treatment and diagnosis provided. I acknowledge that no guarantee had been made as the effect of such examination, treatment or diagnosis of my condition.

5. AGE OF CONSENT. Where minors are involved, the following prevails:
   A. The consent of a parent or legal guardian is required, if the patient is Unmarried and has not yet attained his/her 18th birthday.
   B. The consent of a parent or legal guardian is not required if a patient is Under 18 years of age has contracted a valid marriage, regardless of subsequent divorce or annulment.
   C. Parental or spousal consent is not required for the treatment of sexually transmitted diseases for family planning services.

6. CIRCUMSTANCES OF CONSENT. The undersigned certifies to understand and agree to the foregoing, and certifies to being the Patient of his/her representative duly authorized to execute the above and accepts its terms personally and/or upon the Patient's behalf.

Signature of Patient or Authorized Legal Representative	Date	Relationship to Patient

Witness	Date

JAY R. WALTHER, M.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Jay R. Walther, M.D. to release any or all medical information about myself including AIDS/HIV test results and diagnosis, drug/alcohol abuse and/or psychiatric diagnosis and treatment records to my insurance company (s). Additionally, I authorize without further action by, on my behalf, said to disclose all or any part of my records to any part of my records to any person or corporation (including but not limited to: hospital or medical service companies, insurance companies, worker's compensation carriers, welfare agencies, and/or my employer) who is or may be liable under a contract to (1) any of the physicians listed above, (2) the patient, (3) a family member, or (4) the patient's employer, for all or a portion of the physician's fee for services rendered. This notice is in effect until further notice is provided by myself.

I further authorize the above mentioned physician to release my social security number as it pertains to the filing of insurance claims and the exchanging of authorized medical record information.

Patient signature_____ Date_____

Witness_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

I request that authorized Medicare benefits, or other insurance benefits, be made on my behalf to the above named physician for services rendered by that particular physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents. Any information needed to determine these benefit or benefits payable for related services.

Patient signature_____ Date_____

Witness_____ Date_____

JAY R. WALTHER, M.D. FINANCIAL POLICY

Jay R. Walther, M.D. realizes that the financial aspects of medical care are an important part of your visits with us. As such, we want to let you know "up front" what our policies and expectations are for our patients regarding payment for health care services.

Jay R. Walther, M.D. does expect payment at the time of your visit with us. We may ask for your co-pay right before you see the physician. For you convenience we accept Visa, MasterCard, Discover, cash, money orders, traveler's checks and personal checks.

Payment at the time of service accomplishes two things: 1) You clear your account immediately and do not have to be concerned with outstanding balances; and 2) We can keep our fees reasonable for your benefit. Monthly statements are expensive and, unfortunately, increase the cost of medical care for our patients. We understand that there may occasionally be times when you will need to make payment arrangements. We have a very competent, understanding staff that will assist you in setting up appropriate payment arrangements.

INDEMNITY COMMERCIAL INSURANCE

This is a "regular" insurance plan that does not typically use a physician network. These plans will have a deductible for the calendar year after which they reimburse you a percentage for each visit. We will require that you pay for your services in full, even if you have met your deductible. We are not in a contract with these insurance plans; however, we will be happy to send a claim to your plan if you wish. Your insurance carrier should send you any reimbursement that is due.

MEDICARE

Jay R. Walther, M.D. participates in the Medicare Program. Should you require hospitalization, we will be glad to assist by filing secondary claims for you. There are some secondary and supplemental plans that Medicare files automatically for you. If you are unsure if you have one of these plans, please check with our business office.

> We require that you pay 20% of what Medicare allows for today's services, and any deductibles that you may still need to meet for this Calendar year. Please note that there may be services that you wish to receive that Medicare does not cover. Such services will be your responsibility. These include wellness checkups and any visits for which you do not have a symptom, an illness, or an injury. Please see the business office if you have any questions regarding such visits.

HMO COVERAGE

Valley Health Plans Principal HealthCare of Texas BC/BS Group 38000, 38001 or 38002

These plans require that you have a PCP (Primary Care Physician) selected prior to receiving services. Your PCP may be a physician elsewhere that has referred you to our office to see a specialist.

- You will need to pay the office co-pay today. See your insurance card for this amount.
- If you were referred to see Jay R. Walther, M.D., please be certain that you have a referral from your PCP to receive services. Otherwise, you will be responsible for the full amount of the visit today.

Please see the next page

PPO NETWORK INSURANCE

Our physician participates in several insurance programs and PPO's. Please speak with our billing department if you have questions regarding your individual health insurance plan. If your plan requires an office co-pay, you will be required to pay before your office visit. Your co-pay may not be all that you will be held responsible for. Please see the following circumstances in which we will look to you for payment in full on this account.

- If your insurer decides that services rendered to you were "medically unnecessary" we will turn the claim to your responsibility and look to you for payment in full.
- Additionally, if your insurer holds up the processing of your claim for any reason for more than 60 days after your visit with us, we will turn the claim to your responsibility and look to you for payment.
- If your insurer denies payment for a preexisting condition, we will turn the claim to your responsibility and will look to you for payment.

If our physician is not a participating provider, you will be required to pay for your visit in full today.

We send out statements to our patients once per month. These will show the portion that you are currently responsible for. Please be aware that this amount may change as additional insurance payments come in. If you should have any questions about your benefits through your insurance carrier, please call the number on your insurance card.

MEDICAL RECORDS

As a courtesy, Jay R. Walther, M.D. does not charge for medical records when forwarding them to another physician's office. Jay R. Walther, M.D. does charge for copies of medical records when patients request records for personal use. If you have questions regarding the fees for medical records, please ask questions.

I have reviewed a copy of the financial policies for Jay R. Walther, M.D.

Patient's Signature_____ Date:_____

Patient's Printed Name_____

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date

JAY R. WALTHER, M.D.
628 N. ED CAREY DRIVE
HARLINGEN, TEXAS 78550

TELEPHONE (956) 423-1121 FAX (956) 423-1202

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I, _____ HAVE REVIEWED A COPY OF JAY R. WALTHER, M.D. NOTICE OF PRIVACY PRACTICES.

I authorize Dr. Walther to release medical information to the following people.

NAME _____ PHONE # _____

NAME _____ PHONE # _____

NAME _____ PHONE # _____

_____ _____
SIGNATURE OF PATIENT DATE