

Thank you for choosing our office for your health care. We strive to provide the best possible care for you and your family

PATIENT INFORMATION

PATIENT'S NAME: _____ Sex: M / F
Marital Status: Single Married Separated Divorced Widowed

Address: _____ Date of Birth: ____/____/____
City: _____ State _____ Zip _____ Home Phone () _____ - _____
Mobile Phone () _____ - _____
Social Security #: _____ - _____ - _____ Work Phone () _____ - _____

If Patient is a **Child or Teenager**, please complete the following:

Your relationship to the Patient: Parent Step-parent Guardian Other

If parents are divorced, are you the Custodial parent? Yes / No; if **yes, please provide the office with a copy of your custody agreement.**

Your marital status: Single Married Separated Divorced Widowed

Your Name: _____ Social Security #: _____ - _____ - _____
Address: _____ Date of Birth: _____ - _____ - _____
City: _____ State _____ Zip _____ Home Phone () _____ - _____
Mobile Phone () _____ - _____
Work Phone () _____ - _____

How did you hear about our office? _____

PAYMENT POLICY

Please be aware that we expect payment at the time of your visit. We consider this to be a part of successful treatment.

Payment may be
Cash
Check
ATM/Debit Card
MC/Visa/Discover/American Express

CANCELLATION POLICY

The office requires **AT LEAST 24 HOURS NOTICE** of appointment cancellations. We realize your time is important and therefore strive to begin and end appointments on time. We do not “double book” or “over schedule” appointments. With less than 24 hours notice, we are unable to fill that time. You may call and leave a message on the answering machine at any time.

Our Policy is: *100% of the fee for all missed or ‘late cancel’ (less than 24 hours) appointments.*

I understand the cancellation policy _____ (initial)

CUSTODIAL PARENT FINANCIAL POLICY

Only the custodial parent is able to authorize treatment. The custodial parent is responsible for the full fee for services. We will not bill a second party. A copy of the divorce decree specifying custodial issues must be brought and kept on file.

UNACCOMPANIED TEENAGERS OR OTHER DEPENDENTS

We expect payment at the time of the visit. Patients should come with cash, check or credit card. A credit card authorization may be filled out by the cardholder and kept on file.

I understand the this Policy _____ (initial)

PRESCRIPTION POLICY

RITALIN, DEXEDRINE, ADDERAL, CONCERTA, METADATE, FOCALIN, etc must be filled within 21 days of being written. They cannot be called into a pharmacy. When needing a refill, the office should be notified at least 3 days prior to the medication running out. We shall mail the prescription to your home address

FOR ALL OTHER MEDICATIONS

Call your pharmacy to request a refill, or

Call the office 3 days before your prescription runs out. We cannot guarantee that your prescription will be called to the pharmacy the same day you request.

TELEPHONE POLICY

Dr. Sellers strives to return non-emergency calls either late that evening of the day of the message or the following morning. For emergencies, call the office, and select option “3”; you will be transferred to Dr. Sellers’ mobile phone. If he does not answer, leave a message with your phone number and the time of your call; he will get back with you as soon as possible.

OFFICE HOURS

The office is routinely open Monday through Friday, 10 am – 7pm. Generally, we are out of the office during lunchtime. If you are coming to pick up a prescription or paperwork, **please call to confirm** that someone will be available in the office.

PATIENT CONTACT INFORMATION

Email is not secure. That is, email is like a postcard which anyone can read. Federal regulation requires that your health information must be protected. We use a service *MessageGuard* – that allows us to encrypt email we may exchange.

You will be sent an email from Dr. Sellers that will ask you to register with *MessageGuard* (Network Solutions). You simply enter a unique password. Once registered, you may send secure email to Dr. Sellers.

With email you may request a medication refill, appointment, or ask brief questions. Email should never be used to cancel an appointment.

Email should never be used for emergencies.

_____ (initial) I understand the Email policy

We may find it necessary to leave a message on your personal answering machine or voice mail system if you are unavailable. These messages may contain confidential information; for instance, the fact that you are our patient (e.g. returning your call). These messages may be heard by people other than you. If it is acceptable to leave a message on your service, please initial below.

_____ Yes _____ No

At times there may be a need to send or receive information concerning your medical condition to or from another office, school, laboratory, hospital, etc. Please initial below if it is acceptable to use FAX communication.

_____ Yes _____ No

To expedite your health care and in the interests of convenience, Dr. Sellers may use mobile and / or cordless telephones to discuss your condition with you or other providers, hospitals, etc. There is the possibility unauthorized persons may intercept or overhear such conversations; however, this is not routinely anticipated. The policy of this office is to occasionally use a mobile or cordless telephone. If this is acceptable to you, please initial below.

_____ Yes _____ No

TRICARE / MEDICARE ELIGIBLE BENEFICIARIES

*Dr. Sellers is a **NON-AUTHORIZED TRICARE and MEDICARE physician.** This means you **cannot** use these benefits. You **cannot** pay cash for your visit and then later file a claim. We are sorry that this is so. We will be happy to explain our reasons for this policy. Please indicate your status by signing under the paragraph that describes your situation best.*

I / my child **is not** covered by TRICARE or MEDICARE. (MOST COMMON)

Signature date

I / my child **is eligible** for TRICARE or MEDICARE. I understand I could see a physician who accepts TRICARE or MEDICARE and would only have to pay my deductible and copayment. By signing below I voluntarily agree to not file any claim with TRICARE or MEDICARE for any visit I have with Dr. Sellers. I may stop seeing Dr. Sellers at any time and have my care transferred to a participating physician. (please go to <http://www.drillers.net/documentlibrary.html> and print TRICARE/Medicare Private Contract)

Signature date

**I have read the Financial Policy.
I understand and agree to this Financial Policy.**

Signature of Patient or Responsible Party

date

Witness

date

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.**
- **Copies of the notice are available at www.DrSellers.net and the office**

Signature of Patient or Personal Representative

Date

This page is optional

You may choose to leave a credit card “on file” to pay for your visits. You can stop this at any time. If you wish to do so, please complete the information below.

I authorize: Randall V. Sellers, MD to keep my signature-on-file and charge my credit / debit card:

Credit Card: Visa®, MasterCard®, Discover® and American Express®

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

Zip code: _____

Street Address: _____

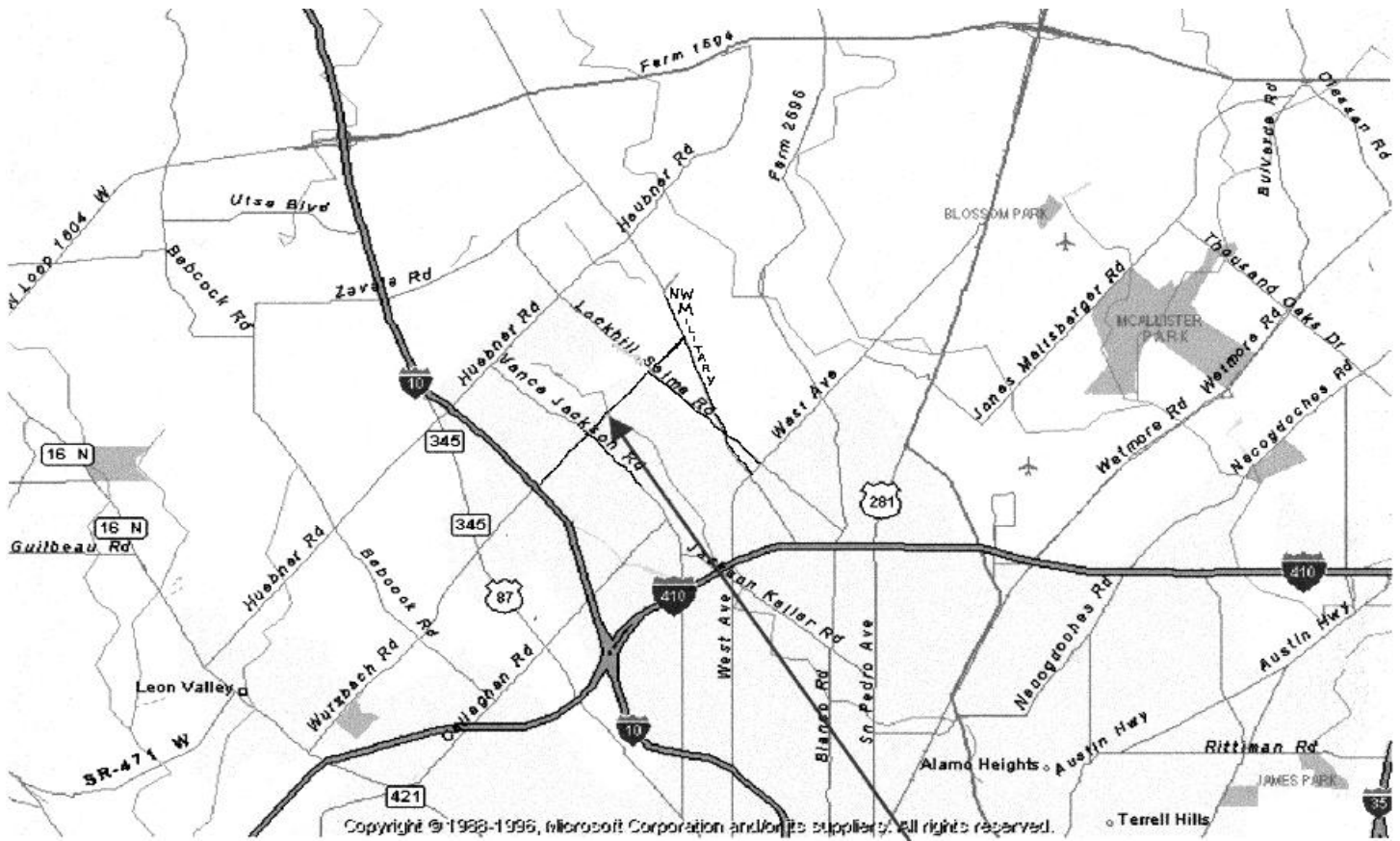
Card code: _____

Cardholder Signature:

_____ **Date:** _____

Preauthorized Credit Card Signature “On File”

Patient Name



- Dr. Sellers' office is located in North Central San Antonio.
- It is on Wurzbach Road between Vance Jackson and Locke-Hill Selma.
- Oak Ridge Square is a 4 building office complex. Each building has its own street address.
- Dr. Sellers' building is the right rear building.
- Go around to the right side of the complex. The building directory is between the front and rear building. Dr. Sellers' name and suite (201) are on the directory.
- Go down the steps, through the glass door, up the steps to the 2nd floor. Turn right and the office is on your left

