BRADLEY D. FULLERTON, MD
Physical Medicine & Rehabilitation

Welcome to ProloAustin!

We are pleased that you have chosen us at ProloAustin. Our philosophy is to empower you to actively participate in your own healing. Even though your treatment here may focus on a specific area of your body, your whole body participates in the healing process. With that in mind, it is important for us to know when you have other ongoing health concerns, even when they are being managed by another provider. Please keep us updated on any other health concerns you may be dealing with as well as any medications and supplements you may be taking as they change. We believe that communication with our patients allows us to provide the best possible service to you.

INSURANCE:

Physicians, patients and insurance carriers enter into a three-way relationship to provide medical care. We assume the responsibility for providing high quality medical care and, according to our contract; we file insurance claims on your behalf. Your insurance carrier has the responsibility to pay claims promptly and accurately without undue delay. We count on you to know your insurance benefits, provide us with accurate filing information, and to be attentive to making sure that your insurance carrier is paying claims in a timely manner.

See "Your Health Coverage" on the Texas Department of Insurances consumer website (www.tdi.state.tx.us/consumer/cobo05.html) to find answers to your insurance questions, learn more about your rights, and to receive guidance on managing timely involvement in any insurance partnerships created.

OUR POLICIES: Please initial each line

1. _____Primary Care Referrals: Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral. You will also need to make sure and continue to get all necessary referrals from your PCP as needed during your course of treatment.

2. _____Co-Payments: Co-payments, deductibles and all non-covered services by your insurance carrier, (prolotherapy, ultrasound and trigger point therapy, depending on your insurance plan) must be paid for at the time of service.

3. _____Insurance: As a courtesy to you, we will file your primary insurance for you; any secondary insurance will be patient responsibility to file. Any insurance filed and not paid within 45 days will be billed to the patient and payment will be expected from the responsible party.

4. _____Attire for Ultrasounds and Procedures: Shorts or sweatpants with an elastic waistband may be ideal, particularly if we are treating or examining the lower extremities. For upper extremities you may wish to wear clothing that the area can be accessed easily.

5. _____Tardiness: Please plan to arrive 10 minutes before your appointment time to allow time for updating your medical information. Our goal is to have the doctor start his visit at your appointment time. Please call if you are running late. Patients arriving more than 5 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time. If we are running late, the session will be completed in its entirety.

6. _____Cancellations: We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment slot. There will be a $50.00 charge for patients canceling without appropriate notice.

7. _____Prolotherapy Appointments: Must be cancelled 48 hours prior to the appointment; cancellations within 24 hours will be assessed a $50 charge; missed or late cancellations will be assessed at the rate of the entire visit. After 2 such cancellations in a six-month period it will be necessary to pay in advance for your appointment.

8. _____Repeated Missed Appointments: We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.

9. _____Medication Refills: To ensure that your medication needs are met in a timely manner, we request you call your pharmacy for a refill a week prior to the date your medication is scheduled to run out. Our office needs 3-5 business days to complete a medication refill.

10. _____Triplicate Prescriptions: If you will be getting monthly narcotics prescriptions, you will need to sign a narcotics contract and also have a monthly appointment with our nurse for your refills. The refills will only be handled in this manner.

You may find us on the web at www.proloaustin.com

I have read and agree to abide by the policies of Bradley D. Fullerton, MD.

_____ _____

Patient/Guardian Date

PROLO AUSTIN

BRADLEY D. FULLERTON, MD
Physical Medicine & Rehabilitation

PERSONAL AND INSURANCE INFORMATION

Items marked with * are required. Please write legibly.

*NAME_____

*Last *First Middle

*ADDRESS_____

*CITY_____*STATE_____*ZIPCODE_____

*HOMEPHONE#_____MOBILEPHONE#_____

*MOSTLIKELYPHONE#ATWHICHYOUCANBEREACHED?_____

EMAIL ADDRESS _____ *GENDER M or F MARITAL STATUS M D S W

*DATEOFBIRTH_____/_____/_____*SOCIALSECURITYNUMBER_____-_____-_____

*REFERRINGPHYSICIAN_____PHONE#_____

*GUARANTOR/RESPONSIBLEPARTY_____RELATIONTOPATIENT_____

*GUARANTOR'SADDRESS_____

*CITY_____*STATE_____*ZIPCODE_____

*GUARANTOR'SSOCIALSECURITY#_____-_____-_____*DATEOFBIRTH_____

*GUARANTOR'SEMPLOYER_____*EMPLOYERPHONE#_____

*POSITION_____*EMPLOYERADDRESS_____

*CITY_____*STATE_____*ZIPCODE_____

*PRIMARYINSURANCE_____PHONE#_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

*POLICYNUMBER_____*GROUPNUMBER_____

*SECONDARYINSURANCE_____

*POLICYNUMBER_____*GROUPNUMBER_____

*ARE YOU COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN? _____ YES _____ NO

*IFYES,PLEASELIST_____*GUARANTOR_____

*POLICYNUMBER_____*GROUPNUMBER_____

*ISANATTORNEYASSOCIATEDWITHYOURCASE?YNNAME:_____

EMERGENCYCONTACT_____PHONE#:_____

ADDRESS_____

CITY_____STATE_____ZIPCODE_____

If your insurance requires a referral or authorization number, it is the PATIENT'S responsibility to present that referral or authorization number at time of visit. I authorize payment of medical benefits to Dr. Bradley D. Fullerton. I authorize the release of any information needed to determine these benefits payable for related services.

_____

Signature of Patient or Insured Date

Notice of Privacy Practices Acknowledgement of Receipt

By signing this form, you hereby acknowledge that you have received and read the Notice of Privacy Practices of the office of Dr. Bradley D. Fullerton. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to thoroughly familiarize yourself with this document.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice through accessing our website at www.austinprolo.com.

Should you have any questions about our Notice of Privacy Practices please contact Cassi Taylor, Practice Manager, at 512-347-7246. Thank you.

I acknowledge receipt of Notice of Privacy Practices for the office of Dr. Bradley D. Fullerton.

_____

Signature of patient or guardian Date

Communication Consent

HIPPA is the acronym for the Health Insurance Portability & Accountability Act of 1996, a federal law. The Administrative Simplification section of this Act is of concern to our practice and requires us to comply with specific rules regarding 1) unique identifiers for health plans, providers, individuals and employers, 2) healthcare transactions & code sets for transmitting electronic data, 3) privacy regulations over disclosure and use of health information, and, 4) security regulations over protections of electronic health information. All these rules have been developed by the Department of Health & Human Services and will become final in stages.

It will be the policy of the office of Dr. Bradley D. Fullerton not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, e-mail, cell phone, pager and/or fax. Whenever making or returning phone calls to you, and an answering machine picks up, we will not leave a message if the name or telephone number of the resident(s) is not contained in the recorded message. Information will not be left with an unauthorized person who may answer at the phone number of record. We will identify ourselves only as "(employee) with Bradley Fullerton's office". If you would like to have your medical information, i.e., appointment confirmations, etc., released to someone other than yourself, please complete the following: I authorize the office staff of Dr. Bradley D. Fullerton to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home telephone	Yes	No	N/A
Answering machine	Yes	No	N/A
Work telephone	Yes	No	N/A
Voice mail	Yes	No	N/A
Cell phone	Yes	No	N/A
Pager	Yes	No	N/A

Please list authorizations:

Spouse/fiancée	Yes	No	N/A
Parent	Yes	No	N/A
Sibling(s)	Yes	No	N/A
Child(ren)	Yes	No	N/A
Friend	Yes	No	N/A

_____

Signature of patient or guardian Date