James V. Higgins, M.D.
Mark A. Feist, M.D.
Pediatric Gastroenterology and Nutrition
4102 24th Street, Suite 508
Lubbock, Texas 79410
Tel (806) 725-5830 • Fax (806) 725-5837

Covenant
Medical Group

Your child has an appointment with Dr. Higgins/Dr. Feist on _____, _____ at _____am/pm. Please complete the enclosed forms. Bring the forms and your insurance card and or current Medicaid card with you to your appointment. **YOUR APPOINTMENT WILL BE RESCHEDULED IF YOU DO NOT BRING CURRENT MEDICAID CARD AND/OR INSURANCE CARD.** If your insurance requires a referral, you must contact your pediatrician or family doctor to obtain this **BEFORE** your scheduled appointment in our office. Please bring your referral form provided by your doctor's office. You **MUST** have your insurance card and referral with you to be seen in our office.

We are located in the Medical Office Building, which is located across from Maxey Park. Parking may be limited at the time of your visit - please allow plenty of time before your clinic appointment to park and get to the clinic on time.

Please arrive for your appointment at least **15 minutes** prior to your scheduled time as our schedule is set to provide quality care and time for each consultation and any questions you may have. Please obtain any records, X-rays, and lab tests from your primary physician in order to allow for a more complete and thorough evaluation in our office.

We are a provider for many insurance plans so it is best that you check with your insurance company to make sure we are a provider for your plan. You must be prepared to pay your co-pay or the full amount if you have not met your deductible.

Please call our office if you cannot arrive for your appointment as scheduled.

We look forward to seeing you in our office.

JAMES V. HIGGINS
MARK A. FEIST

DATE_____
ACCT_____

WELCOME TO OUR OFFICE
PATIENT INFORMATION

Name _____ Date of Birth_____

Sex M F SS#_____

Address_____ City_____ State_____Zip_____

Home phone (____)_____ Cell Phone (_____)_____

Mother's Name _____ SS#_____DOB_____

Address (if Different)_____ City _____ State_____ Zip_____

Phone (if Different)_____

Father's Name_____ SS# _____ DOB_____

Address (if Different)_____ City_____ State_____ Zip_____

Phone (if Different)_____

Mother's Employer_____ Phone(_____)_____

Father's Employer_____ Phone (_____)_____

Name of person who carries insurance: parent information

Name_____ SS#_____ DOB_____

Address_____ City_____ State_____ Zip_____

Employer_____ Phone(_____)_____

Relationship to patient_____

NOT parent **Emergency Contact**_____ Phone(_____)_____

Pharmacy_____ Phone(_____)_____

Primary Care Physician/Referring Physician_____ Phone (_____)_____

Address_____ City/State/Zip_____

I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

Signature_____, Date_____

Covenant Medical Group

CONSENT TO TREATMENT

I (the patient/guardian/legal representative to the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians and staff of Covenant Medical Group. **PHARMACY/MEDICATION HISTORY:** I authorize Covenant Medical Group to obtain all of my medication history, in any format, to provide my medical care.
This consent is valid from this date forward.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Covenant Medical Group'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 if requested.

ADVANCED DIRECTIVE LIVING WILL

Do you have an advanced directive/living will? __ Yes __ No
If you answered No, would you like more information on Advanced Directives? ___ Yes ___ No

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE PUT A ✓ IN EACH SECTION):

- ☐ Home Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Work Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Mobile Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Fax Number: _____
  - ☐ Please **do not** fax any information to me
- ☐ Written Communication
  - ☐ Mail to my home address
  - ☐ Mail to my work/office address
  - ☐ Please **do not** mail
- ☐ The following people may have access to my medical information:
  - ☐ Spouse/Significant Other: _____
  - ☐ Child: _____
  - ☐ Child: _____
  - ☐ Child: _____
  - ☐ Other:_____
  - ☐ Nobody should have access

The above authorized information will apply to all Covenant Medical Group providers and remains in effect until additional notice or changes are made by the patient.

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other: _____

_____	_____	_____
Printed Name Birthdate	Signature	Date
_____	_____	_____
Printed Name of Witness	Signature of Witness	Date

Form 019 11/20/10 (lifetime)
Legal

Covenant Medical Group

Patient Financial Responsibility

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you and the following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit opportunities.

2. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card at to every visit.
   - Be prepared to pay your co-payment at each visit by cash, check, or credit card.
   - For medical care not covered under your insurance, payment in full is due at the time of the visit.
   - You are responsible for any outstanding balances owed to the Covenant Medical Group for services provided to you or any family member for which you are responsible.

3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service.

4. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you may be financially responsible.

5. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.

6. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card). If your insurance company determines services provided are not covered, the responsible party owes the payment

7. If you fail to make payment in full for the services, your outstanding balance will be sent to a collections agency. If you consistently refuse to pay for services rendered, CMG may choose to cease providing services to you.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be asked prior to services provided. Please sign that you have read and agree to the above mentioned financial information which assigns Covenant Medical Group, and/or any physician who has treated you, all rights, title, and interest in any payment due you for services provided in the policy or policies of insurance including Medicare or Medicaid. I authorize any holder of medical or other information about me to be released to Social Security Administration or its intermediaries/carriers any information needed for this claim. I authorize contact on any phone number I have provided. I agree to pay for charges which may be greater than the amount paid by the insurance company or companies.

_____

Signature of Patient or Responsible Party Date

_____

Signature of Co-Responsible Party Date

COVENANT MEDICAL GROUP

COVENANT BUSINESS OFFICE #03
DATE: April 4, 2005
SUBJECT: Patient Financial Responsibility
APPROVED: CMG Administration
REVISED: November 7, 2012
REVIEWED: November 7, 2012

STATEMENT OF PURPOSE: To define CMG Policy for Patient Financial Responsibility

POLICY:

We are committed to providing you with the best possible medical care. If you have special needs; we are here to work with you and the following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. The total patient balance due is required to be paid at the time services are provided. For your convenience, we accept cash, checks, Visa, MasterCard, Discover, American Express and Care Credit Opportunities.

2. Our office participates with a variety of insurance plans. It is your responsibility to:
   - Bring your insurance card to every visit.
   - Be prepared to pay your co-payment at each visit by cash, check, or credit card.
   - For medical care not covered under your insurance, payment in full is due at the time of the visit.
   - You are responsible for any outstanding balance owed to Covenant Medical Group for services provided to you or any family member for which you are responsible.

3. If you have insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is required at the time of service.

4. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled or you may be financially responsible.

5. If the patient is a minor (18 years or younger), the parent or guardian must sign below. The parent, guardian or unaccompanied minor is responsible for any payment due at time of service, bringing the necessary referrals and insurance card.

6. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services department (number is on the insurance card).

   If your insurance Company determines services provided are not covered, the responsible party owes the payment.

7. If you fail to make payment in full for the services, your outstanding balance will be sent to a collections agency who is authorized to contact you via the number's you have provided. If you consistently refuse to pay for services rendered, CMG may choose to cease providing services to you.

Covenant Medical Group

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____ (optional)

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address:_____

This information may be disclosed to and used by the following individual or organization.

_____ Address:_____

For the purpose of:_____

Please release the following:

- ☐ Problem List
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Medication List
- ☐ Immunization Record
- ☐ List of Allergies
- ☐ All Records
- ☐ X-ray/Imaging Reports - from (date)_____ to (date)_____
- ☐ X-ray films
- ☐ Laboratory Results - from (date)_____ to (date)_____
- ☐ EKG Reports
- ☐ Genetic Testing Information
- ☐ Other Diagnosis Reports (Specify)_____
- ☐ Other (Specify)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes**, I consent to the release of this information. ☐ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact_____ _____*(insert privacy officer or other office or individuals name or contact information).*

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold_____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

Date request completed:_____ # of pages copied_____ Reviewed only_____

Charges:$_____ Cash:_____ Check #:_____ Initials:_____

Covenant
Medical Group

Covenant Medical Group is now required to ask for and document the primary language, race and ethnicity of our patient's. Centers for Medicare and Medicaid Services (CMS) is requiring this data be collected for the meaningful use initiative.
The goal is to improve the US healthcare system by improving quality and efficiency of care, and patient safety.
You may go to the CMS website at: **www.cms.gov** for any questions you may have.

Please circle which option listed below applies to you in reference to **Ethnicity**:

A) Hispanic/Latino/Spanish Origin
B) Not Hispanic/Latino/Spanish Origin

Please circle which option listed below applies to you in reference to **Race**:

A) Asian
B) Black/African-American
C) Caucasian/White
D) Hispanic
E) Native American/Alaskan Native
F) Native Hawaiian/Pacific Island
G) Other
H) Refused
I) Unknown

Please circle which option listed below applies to you in reference to **Primary Language**:

A) Amharic (Ethiopian)
B) Arabic
C) Chinese
D) English
E) French
F) German
G) Japanese
H) Kikuyu
I) Korean
J)Phillipino
K) Portugese
L) Rubu
M) Sign Language
N) Sinhalese
O) Spanish
P) Swahili
Q) Tagalog
R) Urdu
S) Vietnamese

MEDICATION LIST

Please list ALL medications your child is taking at this time. We must have name of medication, strength and instructions for when and how your child is taking each medcation. Ex: Regian 1mg/ml, 0.6cc by mouth four times per day. (If you are unable to find this information on the containers, please either bring the medication with you. or contact your pharmacy). Thank you.

Medication	Strength	Dose	When Taken

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806-725-5837 **Fax**
877-780-7577 **Toll Free**

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DIRECTIONS:

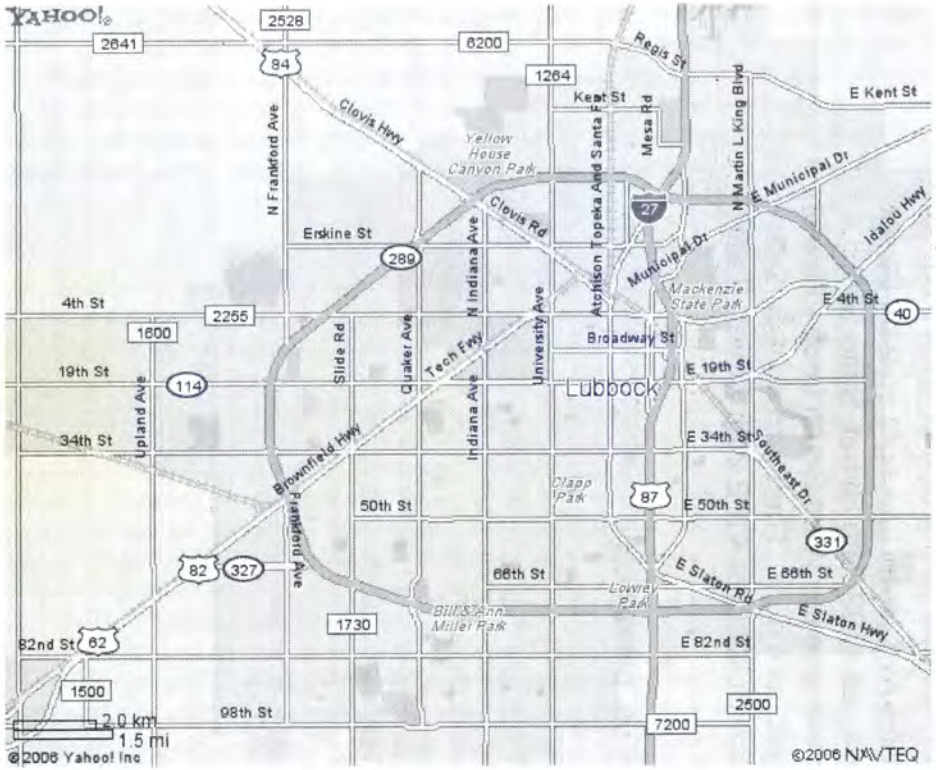
From Interstate 27 / South Hwy 87:
Take the 19th St. exit and go west. Turn left onto Memphis Ave., then turn right on 24th Street. Our office is located at the Medical Office Building at 4102 24th Street, Suite 508, across from Maxey Park.

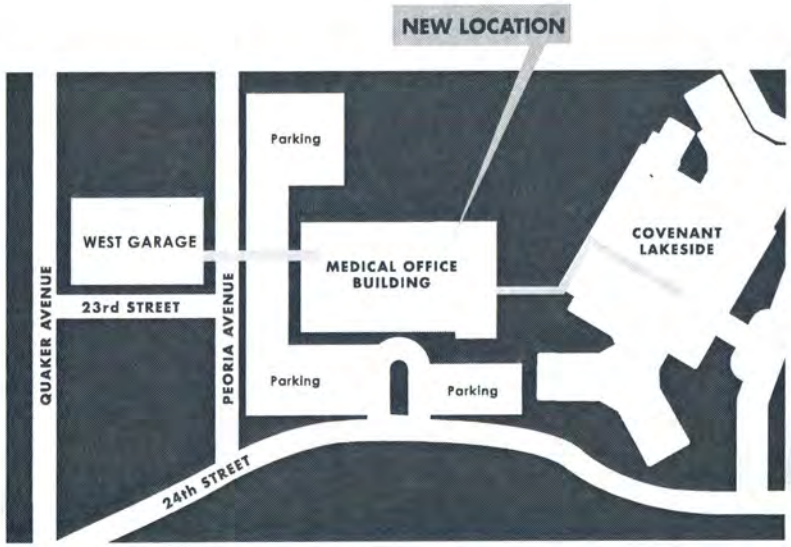
From US 62/82 (Brownfield Hwy / Marsha Sharp Freeway):
Turn right on Quaker Ave. then left on 24th Street. Our office is located at the Medical Office Building at 4102 24th Street, Suite 508, across from Maxey Park.

From Hwy 84 North (Clovis):
From this Hwy, you will turn right onto Quaker Ave., continue south and turn left on 24th Street. Our office is located at the Medical Office Building at 4102 24th Street, Suite 508, across from Maxey Park.

From Hwy 84 South (Slaton, Post, Snyder):
You have two choices from this Hwy. 1. Stay on Hwy 84 all the way through town, then turn left onto 19th St. Turn left onto Memphis Ave., then turn right on 24th Street. Our office is located at the Medical Office Building at 4102 24th Street, Suite 508, across from Maxy Park. 2. From Hwy 84, you will take the West/South Loop 289 exit. From the Loop, you will take the Quaker Ave. exit, turn right. Then turn right on 24th Street. Our office is located at the Medical Office Building at 4102 24th Street, Suite 508, across from Maxy Park.

If you have any questions or need help locating us, please call.





DIRECTIONS

Access to Covenant Medical Center and Covenant Medical Center - Lakeside

From Interstate 27

Take the 19th STreet exit and go west. The Covenant Medical Center campus begins at 19th and Indiana. To get to the Lakeside campus, continue on 19th street to Quaker Ave. The Lakeside Campus begins at 24th and Quaker.

From U.S. 62/82 West

(Lakeside Campus) Exit South at Quaker Ave. The Lakeside Campus bebins at 24th and Quaker. (Medical Center Campus): Exit east at 19th Street. The Medical Center campus begins at 19th & Indiana.

From U.S. 62/82 East:

Follow U.S. 62 west to 19th Street. The Medical Center campus begins at 19th & Indiana. To get to the Lakeside campus, continue on 19th Street to Quaker Ave. The Lakeside Campus bebins at 24th and Quaker.

From U.S. 84 South:

Exit at Interstate 27, go north to 19th Street. Go west on 19th Street. The Covenant Medical Center Campus begins at 19th and Indianan. To get to the Lakeside campus, continue on 19th Street to Quaker Ave. The Lakeside Campus bebins at 24th and Quaker.

How to Find Us

Covenant Health system is located in central Lubbock, with both campuses only four blocks apart. Nearest major thoroughfares include Indiana Avenue to the east, 34th Street to the south, Quaker Avenue to the immediage west of the Lakeside campus and 19th Street to the immediate north of the Medical Center campus.