North Texas Family Medicine

Please print clearly and complete all information so that your claim can be processed quickly and efficiently. Thank You!

Patient Information

Name: (First, Middle, Last)

Date of Birth: **Age:** **Sex: Male/ Female** **Marital Status: S M W D**

Address:

(Street) (Apt #) (City) (State) (Zip)

Phone#: **Social Security#:** **Drivers License #:**

Work #: **Employer:** **Date of Employment:**

E-mail: **Student: Y N Full/ Part Where?**

Responsible Party or Spouse Information

Name: **Relationship To Patient:**

Address:

Phone#: **Work#:** **Social Security#:**

Employer:

Employers Address:

****Emergency Contact:**** Name/Relationship/Phone number

Insurance Information

Insurance Name: **Phone#:**

Insurance Address:

Member Id#: **Group#:**

Insured's Name: **Relationship to Patient: Self/Spouse/Dependent**

Social Security#: **Date of Birth:** **Sex: M/F**

Employer: **Phone#:**

Address:

I hereby assign, transfer and set over to North Texas Family Medicine, P.A., all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I also acknowledge and agree to adhere to the Office/Financial Policies. In addition, I authorize NTXFM to obtain prior prescription history, when medically necessary.

Patients Signature: **Date:**

Who may we thank for your referral?_____

Health History

Welcome to our practice as a new patient please fill out the information found below to the best of your ability.

Patient Name:_____ **DOB:**_____ **Date:**_____

Past Medical History

Have you ever had the following? (Circle "Yes" or "No", leave blank if uncertain)

Measles	Yes	No	Anemia	Yes	No	Back Trouble	Yes	No
Mumps	Yes	No	Bladder Infections	Yes	No	High Blood Pressure	Yes	No
Chicken Pox	Yes	No	Epilepsy	Yes	No	Low Blood Pressure	Yes	No
Whooping Cough	Yes	No	Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Scarlet Fever	Yes	No	Diabetes	Yes	No	Asthma	Yes	No
Diphtheria	Yes	No	Polio	Yes	No	Hives or Eczema	Yes	No
Small Pox	Yes	No	Glaucoma	Yes	No	AIDS or HIV+	Yes	No
Pneumonia	Yes	No	Hernia	Yes	No	Infectious Mono	Yes	No
Rheumatic Fever	Yes	No	Bronchitis	Yes	No	Miral Valve Prolapse	Yes	No
Blood or Plasma			Migraine Headaches	Yes	No	Stroke	Yes	No
Transfusion	Yes	No	Date of Last Chest X-Ray_____			Cancer	Yes	No
Any other Disease:	Yes	No				What Kind?_____		

Please List:_____

_____

_____

Immunization Record

Date		Date		Date		Date			
_____	Hepatitis A	_____	Hepatitis B	_____	Influenza	_____	Tdap	_____ Polio	_____ MMR
_____	Prevnar 13	_____	Pneumovax	_____	Shingles	_____	HPV	____	Tetanus

Previous Hospitalizations/ Surgeries/ Serious Illnesses	When?	Hospital, City, State

Medications: (Include nonprescription)

Name	Strength	How Often

Patient Social History:

(Please Circle which applies)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of Tobacco:	Never	Previously But Quit	Current Packs A Day:_____		
Use of Drugs:	Never	Type:_____	Frequency:_____		
Excessive Exposure at Home or Work to:	Fumes	Dust	Solvents	Air-Borne Particles	Noise

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____

Name _____ **Date** _____

Review of systems: Please indicate any <u>CURRENT ISSUES</u> below:

Constitutional Symptoms:			**Genitourinary:**			**Psychiatric:**		
Good General Health Lately	**Yes**	**No**	**Frequent Urination**	**Yes**	**No**	**Memory Loss or Confusion**	**Yes**	**No**
Recent Weight Change	**Yes**	**No**	**Burning or painful urination**	**Yes**	**No**	**Nervousness**	**Yes**	**No**
Fever	**Yes**	**No**	**Blood in urine**	**Yes**	**No**	**Depression**	**Yes**	**No**
Fatigue	**Yes**	**No**	**Change in force of strain when urinating**	**Yes**	**No**	**Insomnia**	**Yes**	**No**
Headaches	**Yes**	**No**	**Incontinence or dribbling**	**Yes**	**No**			
			Kidney Stones	**Yes**	**No**	**Endocrine:**		
Eyes:			**Sexual difficulty**	**Yes**	**No**	**Glandular or hormone**	**Yes**	**No**
Eye disease or injury	**Yes**	**No**	**Male Testicular Pain**	**Yes**	**No**	**Excessive thirst or urination**	**Yes**	**No**
Wear glasses/ contacts	**Yes**	**No**	**Female pain with periods**	**Yes**	**No**	**Heat or cold intolerance**	**Yes**	**No**
Blurred or double vision	**Yes**	**No**	**Female vaginal discharge**	**Yes**	**No**	**Skin becoming dryer**	**Yes**	**No**
			Female #of Pregnancies	_____		**Change in hat or glove size**	**Yes**	**No**
Ears/Nose/ Mouth/ Throat:			**Female # of Miscarriages**	_____				
Hearing loss or ringing	**Yes**	**No**	**Female Date of last pap**	_____		**Hematological/ Lymphatic:**		
Earaches or draining	**Yes**	**No**				**Slow to heal after cuts**	**Yes**	**No**
Chronic sinus problem or rhinitis	**Yes**	**No**				**Bleeding or bruising tendency**	**Yes**	**No**
Nose bleeds	**Yes**	**No**	**Musculolskeletal:**			**Anemia**	**Yes**	**No**
Mouth Sores	**Yes**	**No**	**Joint Pain**	**Yes**	**No**	**Phlebitis**	**Yes**	**No**
Bleeding gums	**Yes**	**No**	**Joint stiffness or swelling**	**Yes**	**No**	**Past transfusion**	**Yes**	**No**
Sore throat or voice change	**Yes**	**No**	**Weakness of muscles or joints**	**Yes**	**No**	**Enlarged glands**	**Yes**	**No**
Swollen glands in neck	**Yes**	**No**	**Muscle pains or cramps**	**Yes**	**No**			
			Back pain	**Yes**	**No**	**Allergic/ immunology:**		
Cardiovascular:			**Cold extremities**	**Yes**	**No**	**History of skin reaction or other acute**		
Heart trouble	**Yes**	**No**	**Difficulty walking**	**Yes**	**No**	**Penicillin or other antibiotics**	**Yes**	**No**
Chest pain or angina pectoris	**Yes**	**No**				**Morphine, Demerol or other**		
Palpitation	**Yes**	**No**	**Integumentary (Skin/ Breast):**			**narcotics**	**Yes**	**No**
Shortness of breath (walking)	**Yes**	**No**	**Rash or itching**	**Yes**	**No**	**Novocain or other**		
Shortness of breath (laying)	**Yes**	**No**	**Change in skin color**	**Yes**	**No**	**anesthetics**	**Yes**	**No**
Swelling of feet, ankles or hands	**Yes**	**No**	**Change in hair or nails**	**Yes**	**No**	**Aspirin or other pain**		
			Varicose veins	**Yes**	**No**	**remedies**	**Yes**	**No**
Respiratory:			**Breast pain**	**Yes**	**No**	**Tetanus, antitoxin, or other**		
Chronic or frequent coughs	**Yes**	**No**	**Breast lump**	**Yes**	**No**	**serums**	**Yes**	**No**
Spitting up blood	**Yes**	**No**	**Breast Discharge**	**Yes**	**No**	**Iodine, merthiolate or other**		
Shortness of breath	**Yes**	**No**				**antiseptic**	**Yes**	**No**
Sneezing	**Yes**	**No**	**Neurological:**			**Other Drugs/ Medications**		
			Migraine headaches	**Yes**	**No**			
Gastrointestinal:			**Light headed or dizziness**	**Yes**	**No**			
Loss of appetite	**Yes**	**No**	**Convulsions or seizures**	**Yes**	**No**			
Change in bowel movement	**Yes**	**No**	**Numbness or tingling**	**Yes**	**No**	**Known food allergies**		
Nausea or vomiting	**Yes**	**No**	**Tremors**	**Yes**	**No**			
Frequent diarrhea	**Yes**	**No**	**Paralysis**	**Yes**	**No**			
Painful bowel movements or Constipation	**Yes**	**No**	**Head Injury**	**Yes**	**No**	**Environmental allergies**		
Rectal bleeding or blood in stool	**Yes**	**No**						
Abdominal Pain	**Yes**	**No**						

To the best of my knowledge the questions on this form have bee accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

PLEASE READ

<u>Preventive visits and Evaluation and Management (E&M) visits</u>. Sometimes your physician may do an E&M (sick or follow up visit) with your Preventive visit. This will save you from having to return to the office for the E&M visit. However, your insurance may require a copay and/or deductible/coinsurance for the 2 in 1 visit. If you do not want both visits together, please inform the provider prior, and they will just do the physical exam.

_____ _____

Signature of Patient, Parent or Guardian ***Date***

_____

Doctors Signature

North Texas Family Medicine
Board Certified Family Practitioners

AUTHORIZATION AND CONSENT AGREEMENT

Financial/Office Policies

I have read and understand the Financial/Office Policies of NTXFM and agree to abide by its guidelines.

Consent to Obtain Prescription History

I provide informed consent to NTXFM to obtain and review my prescription history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care.

HIPAA

I have reviewed this office's NOTICE OF PRIVACY PRACTICES, which explains how my personal medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Approved HIPAA Contacts

Disclosure of Protected Health Information

Keeping information private is important to us and, by default; we will only disclose information related to the patient's BILLING ACCOUNT and MEDICAL CONDITIONS to the parent or legal guardian. Please note, in order to share protected health inform to your spouse, they must be listed as an approved contact.

The following names are people I would like to be involved in, or have access to my protected health information. I give permission for NTXFM to share my protected health information with:

_____	_____	_____
Contact Name	DOB	Relationship to Patient
_____	_____	_____
Contact Name	DOB	Relationship to Patient

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Office/Financial Policy, Consent to Obtain Prescription History, and Approved HIPAA Contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

_____	_____
Patient Name (Please Print)	Patient DOB
_____	_____
Signature of Patient, Parent, or Legal Guardian	Date

2/18/19

NORTH TEXAS FAMILY MEDICINE
OFFICE/FINANCIAL POLICY AGREEMENT

Thank you for choosing North Texas Family Medicine for your family's medical care. We are committed to providing you with quality, personal health care. We appreciate your commitment to adhere to our Office Policy Agreement. To reduce confusion or misunderstanding we ask that you read this Policy, ask any questions, and sign the Authorization and Acknowledgement section of the Patient Information Form. Other than for true medical emergencies, agreement with this policy is required for all medical care.

GENERAL OFFICE POLICIES:

Appointments: When scheduling an appointment, please be prepared to tell the receptionist the reason for your visit so that we can set aside the appropriate amount of time. Patients are seen by appointment only. We try our best to run on time. Therefore, if you are more than 15 minutes late, it is up to the discretion of the doctor whether we will be able to see you at your time slot. You may be asked to reschedule.

Office Hours: We have office hours Monday through Friday. We are closed for the usual holidays. Remember in emergency situations, always call 911. One of our doctors is available 24 hours a day for urgent situations. Just call the office phone and follow the directions for the Urgent Care Mailbox.

New Patients: Both doctors welcome new patients to our practice. It is a good idea to verify the doctor's name as a provider on your insurance web site. It is your responsibility to verify that we are in-network.

Terminating Relationship: Unfortunately, it is sometimes necessary to terminate the patient/physician relationship. If this does happen, the other physician in our practice will also not be able to see you.

Hospitalization: If the situation arises that you do need hospitalization, we have a relationship with a group of in-patient specialists that will care for you while you are in Medical City Plano.

PRESCRIPTION REFILLS: Please call your pharmacy if you need additional refills, except for Controlled Substances. These requests come and are sent back electronically. New prescriptions will not be issued without first seeing a physician. Prescriptions for acute care or chronic conditions are usually written with an appropriate number of refills to complete the course of treatment or to last until your next recommended return to clinic. Please be aware of when the provider wants you to follow up. Please allow 48 hours for any prescription refills.

PATIENT PORTAL: Our patients have access to some of their medical records through our patient portal. We communicate with patients this way, especially for lab/imaging results. This is HIPPA secure. You will be provided a user name (Case Specific) and a temporary password. If you use the HEALOW app on your smart phone, you only have to remember a 4 digit pin.

FINANCIAL POLICY AGREEMENT:

Payment is required at the time services are provided, unless other arrangements have been made in *advance*. We accept cash, personal in-state checks, and VISA, MasterCard, Discover and American Express credit cards. There is a $35.00 service charge for returned checks. However, no checks will be accepted for an initial visit.

INSURANCE: We participate in many managed care plans and will bill your insurance plan, per our contract. If we do not participate with your managed care plan, payment in full is required at the time of service. If you are without health insurance and you are enrolled in the Jefferson Independence Card (www.jeffersonicard.com) your payment may be substantially reduced at the time of service! Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is *your* responsibility; please contact customer service at your insurance company for questions you may have regarding your coverage. ***You are responsible for any services not covered by your plan***.

- **Proof of Insurance**. All patients must complete our Patient Sign-in Form at each office visit. You must furnish valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provide false or *expired* insurance information you will be responsible for the balance of the claim. Please notify us of any changes in insurance coverage prior to time of service. Insurance denials for termination of coverage will be automatically billed to you.
- **Co-payments and deductibles**. All co-payments must be paid prior to time of service. Deductibles and co-insurance will be calculated as best we can at check out. By contractual law, protection of your insurance benefits requires us to charge for, and you to pay for, all required co-payments, co-insurances, deductible and non-covered services. Some plans have a copay only for sick visits, and a deductible for other services, e.g. labs, immunizations, procedures.
- **Claim submission**. We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be

aware that the balance of your claim is your responsibility to pay whether or not your insurance company has paid. Your insurance is between you and the insurance company.

- **Responsible Party**. The adult patient is the responsible party for services rendered. If the patient is a child, the parent bringing the child to the appointment is responsible for all co-payments, co-insurances, and outstanding balances. We will provide a receipt of payment in order that retrieval for payment can be refunded to the paying parent.
- **Preventive visits and Evaluation and Management (E&M) visits**. Sometimes your physician may do an E&M (sick or follow up visit) with your Preventive visit. This will save you from having to return to the office for the E&M visit. However, your insurance may require a copay for the 2 in 1 visit. If you do not want both visits together, please inform the physician prior.
- **Referrals**. If your managed care plan requires approval or authorization for referrals to a specialist, radiological imaging, medical facility care, *etc.*, it is ***your*** responsibility to inform the office of this requirement ***prior*** *to* referral. We require 48 hours notice to facilitate a referral request and cannot issue retroactive referrals. If the specialist we refer you to is not in your network, it is your responsibility to find an alternative specialist in your network.

SELF PAYMENT: We recognize that some of our patients may be without insurance coverage or may chose to receive care even when we are not "Participating Providers" with their managed care plan ("Out-Of-Network"). We do not believe in, nor do we endorse, charging a fee greater than the fees we have agreed to receive from most managed care networks. Therefore, we have been instrumental in founding and developing the **Jefferson Independence Card** as a way in which you can receive services at costs similar to the fees paid by many major managed care plans. To learn more, and to obtain similar discounts on other health care services, please visit **www.jeffersonicard.com**.

OTHER SERVICES, CHARGES AND PATIENT RESPONSIBILITIES: Insurance coverage generally does not include coverage for many administrative services, such as requests for information, prescription refills or after-hours medical consultation. ***The following services may have an administrative services charge that will be billed directly to you and are your responsibility for payment.*** Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

- **Missed appointments**. Broken appointments represent not only a cost to us, but also an inability to provide services to others who could have been seen in the time set aside for you. We require 24 hour notice of cancellation to avoid a ***$25-$75 cancellation fee*** (depending on the type of appointment). It is your responsibility to remember your appointment.
- **Prescription authorizations**. We will honor prior authorization requests from the patient only, but the patient will be responsible for contacting their insurance company to have them forward the prior authorization form to our office. The patient will need to ask their insurance plan what "alternative medications" are covered by their plan. Medication changes will not be done over the phone; if a medication change is requested, the patient must see the physician.
- **Web Interview**. Sometimes your physician may ask if you would like to do a Web Interview versus coming into the office for appointment. ***There will be a $50 fee that will not be billed to your insurance.***
- **Form completion**. All forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork – will be subject to an administrative fee. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with forms completion.
- **Health care advice**. With the advent of the Internet and other sources of health information, we find that we are often consulted for health care advice, oftentimes not related to the patient's current medical care or needs. Providing such information may require considerable thought and/or investigation on our part to coordinate with the patient's exact medical condition. Therefore, any such advice – when unrelated to the patient's current medical condition – may be subject to an administrative fee of $75 per quarter hour of investigation and response.
- **After hours calls**. ***All after hours calls for non-emergency issues are subject to a $25 fee*** that will be billed directly to you and is your responsibility for payment.
- **Requests for medical records**. In accordance with Texas law, North Texas Family Medicine requires written requests for the release of medical records. The administrative fee associated with copying medical records is based on current Texas law, which allows up to 15 business days to get the requested copies to you. Please take this into consideration when requesting copies of your medical records. Expedited copies will be charged an additional fee.

All patients are required to acknowledge their understanding of and agreement to comply with this Office Policy Agreement by signing the Authorization and Acknowledgement section of the Patient Information Form prior to establishing care with North Texas Family Medicine. Current patients agree by acknowledgement on the sign in sheet. Except for emergency care, patients may be denied services for their failure to agree to this Agreement.