centennial

Family Medicine at East Frisco

PATIENT DEMOGRAPHIC INFORMATION FORM Physician:_____

PATIENT'S FULL NAME		MAIDEN NAME	
ADDRESS	APT#	EMAIL PHONE ( ) -	
CITY	STATE ZIP	CELL ( ) - WORK ( ) -	
GENDER: ☐ M ☐ F	MARITAL STATUS ☐SINGLE ☐DIVORCED ☐MARRIED ☐WIDOWED	DATE of BIRTH _____	PATIENT'S SOCIAL SECURITY _____
ETHNICITY: Hispanic or Non-Hispanic	RACE:	PRIMARY LANGUAGE:	
PATIENT'S EMPLOYER			
EMPLOYER'S ADDRESS			
SPOUSE/GUARDIAN'S NAME	WORK ( ) - CELL ( ) -	DOB	SOCIAL SECURITY
EMPLOYER	ADDRESS		
EMERGENCY CONTACT	RELATIONSHIP	PHONE ( ) -	
PRIMARY INSURANCE COVERAGE			
INSURANCE COMPANY	INSURED'S DOB	☐SELF ☐PARENT ☐SPOUSE ☐OTHER_____	
NAME OF INSURED		COPAY AMOUNT	
INSURED'S EMPLOYER			
INSURANCE CLAIM'S ADDRESS		INSURANCE PHONE ( ) -	
CITY	STATE ZIP		
POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY	
SECONDARY INSURANCE COVERAGE			
INSURANCE COMPANY	INSURED'S DOB	☐SELF ☐PARENT ☐SPOUSE ☐OTHER_____	
NAME OF INSURED		COPAY AMOUNT	
INSURED'S EMPLOYER			
INSURANCE CLAIM'S ADDRESS		INSURANCE PHONE ( ) -	
CITY	STATE ZIP		
POLICY NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY	
ANY OTHER INSURANCE COVERAGE ☐YES ☐NO	COMPANY NAME	PHONE ( ) -	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		PRIMARY CARE PHYSICIAN	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Centennial Family Medicine to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Centennial Family Medicine at East Frisco. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: _____ SIGNATURE: _____

15950 Eldorado Parkway, Ste. 400 Frisco, TX 75035
Phone: 214-390-5388 Fax: 972-547-0513 www.centennialfamilymedicine.com

Centennial Family Medicine Financial Policy and Authorizations

We are happy that you selected Centennial Family Medicine at East Frisco for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

Patients are expected to provide identification and if insured, a current insurance card(s) at time of service. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship. Returned checks will be subject to fees.

Medicare: The office will bill the Medicare intermediary. Patients are responsible for the following:

- Annual Medicare deductible
- All applicable co-pays of the allowed charge
- Any non-covered services
- Any covered service ordered by the physician which does not meet Medicare's medical necessity and for which the beneficiary signed an Advanced Beneficiary Notice (ABN).

Medicare Supplemental and Secondary Insurances: The Practice will bill both Medicare and secondary insurances.

Medicaid: Patients must provide the Practice with a current Medicaid card at each visit. Medicaid patients are responsible for applicable co-pays and for all non-covered services. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

HMOs and PPOs, Commercial Insurance Plans: Patients are responsible for payment of the co-pay, co-insurance and/or deductible, or non-covered amounts at the time of service as well as for any charges for which the patient failed to secure prior authorization, if authorization is necessary. Insurance is filed as a courtesy and benefits are authorized to be paid directly to the Practice. Patients are responsible for the balance in full if not paid by the insurance within 30 days. If the patient is not prepared to pay the co-pay or deductible, a member of the clinical staff will determine if it is medically necessary for the patient to see the physician. If the patient's condition allows, the appointment will be rescheduled.

Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

Worker's Compensation: Employer authorization must be obtained before treatment is rendered or the patient will be responsible for payment in full at the time of services for all services rendered. Once authorized, patients are not responsible for any charges unless the workers compensation case is dismissed or denied.

Personal Injury/Motor Vehicle Accidents and Other Third Party Liability: The patient is responsible for the balance in full at the time of service. Any settlement you receive from your insurance company or other third party will be handled by you, your insurance company, and/or your attorney.

Out of State Insurance: If the patient presents with an out of state HMO/PPO insurance card, we will need to verify the patient's benefits for out-of-state or out-of-network benefits. The patient may be required to make payment in full or pay any co-pay, co-insurance or deductible.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

_____ _____

Patient or Parent/Guardian if Minor Date

CENTENNIAL FAMILY MEDICINE AT EAST FRISCO

A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt–out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date:_____

***Minors or Users Requiring Caregivers – Acknowledgement of Consent to Contact**

Name: _____ Relationship to Patient: _____

Signature: _____ Date:_____

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NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Centennial Family Medicine to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Centennial Family Medicine any information obtained in the adjudication of any claim for services furnished to me by Centennial Family Medicine
- I acknowledge that Centennial Family Medicine, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____

Date: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Centennial Family Medicine to (check all that apply):

☐ Leave a detailed message on voice mail/machine

☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me

☐ Transmit and Receive messages through Patient Portal (NextMD or Other) including secure email

☐ None of the above

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Signature of Patient/Guardian: _____ Date: _____

Version 1

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RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____

Last First Middle

Home Address:_____

_____

Home Telephone:_____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes

☐ Discharge Summary ☐ Progress/Physician Notes ☐ X-Ray Report ☐ Pathology Report

☐ History & Physical ☐ Nurses Notes ☐ EKG/EMG/EEG Report ☐ Consult Report

☐ Emergency Report ☐ Laboratory Report ☐ Operative Report ☐ Entire Record

☐ Other_____

Records for the period (dates) from _____ to _____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

RECIPIENT: Name of person or class of persons to whom Centennial Family Medicine may disclose my health information: _____

Address of the recipient or where my health information should be delivered:_____

_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20____.

☐ Until Centennial Family Medicine fulfills this request.

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE: I authorize Centennial Family Medicine to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): [Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization] _____

_____

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RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Centennial Family Medicine discloses my health information to the recipient, Centennial Family Medicine cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Centennial Family Medicine may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Centennial Family Medicine; except, however, if my treatment at Centennial Family Medicine is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Centennial Family Medicine may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Centennial Family Medicine Privacy Office at the address listed below. The revocation will be effective immediately upon Centennial Family Medicine receipt of my written notice, except that the revocation will not have any effect on any action taken by Centennial Family Medicine in reliance on this Authorization before it received my written notice of revocation.

I may contact Centennial Family Medicine **Privacy Office by mail at:**

_____ **or by e-mail at HHH-Privacy@TenetHealth.com.**

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Centennial Family Medicine **to use or disclose my health information in the manner described above.**

_____ _____

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date

PEDIATRIC PATIENT INFORMATION

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE AND WILL NOT RELEASE WITHOUT SIGNED CONSENT UNLESS REFERRED TO BY ONE OF THE PHYSICIANS IN THE CENTENNIAL FAMILY MEDICINE & WELLNESS OFFICE-PROSPER.

CHILDS NAME:_____ **DATE:** ___/_____/_____
LAST FIRST MI

DATE OF BIRTH (DOB): ____/_____/_____ **AGE:**_____ **GENDER: M / F**

MOM'S NAME/D.O.B.:_____ **DAD'S NAME/D.O.B.:**_____

FREFERRED PHARMACY: _____
NAME PH. NUMBER

PREVIOUS PHYSICAN: _____
NAME PH. NUMBER

BIRTH HISTORY
ILLNESSES/COMPLICATIONS DURING PREGNANCY:_____
SMOKING,ALCOHOL,DRUGS SURING PREGNANCY: Y / N _____
TYPE OF DELIVERY (please check from list)
- o Vaginal Delivery
- o Vaginal Delivery with Vacuum (reason:_____)
- o Vaginal Delivery with Forceps (reason:_____)
- o C-section (reason:_____)

DELIVERY WAS _____ HOURS LONG.
PREGNANCY WAS_____ WEEKS LONG.
BIRTH WEIGHT:_____ BIRTH LENGTH:_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS.
If the answer is yes, please provide additional information in the space provided.

PRENATAL CARE: Y / N _____
ADOPTED: Y / N _____
PASS HEARING TEST: Y / N _____
JAUDICE BABY: Y / N _____
SEPSIS EVALUATION: Y / N _____
INFANT DISTRESS: Y / N _____
OXYGEN REQUIRED: Y / N _____
STAY IN NICU: Y / N _____
BIRTH DEFECTS: Y / N _____
STATE SCREENING CONDUCTED: Y / N _____
MEDICATIONS REQUIRED: Y / N _____
DATE OF DISCHARGE: Y / N _____

BREASTFED/FORMULA/BOTH?_____ IF FORMULA, KIND?_____

ALLERGIES: (Medications, Food, Insects)_____
MEDICATIONS: (Please include vitamins and herbals)_____
_____

MEDICAL CONDITION(S)/SURGERIES/ HOSPITALIZATIONS-
Excluding hospitalization at birth. Example: Asthma, Pneumonia:

_____
_____
_____
HAD CHICKEN POX? Y / N DATE (or approximate): ____/____/_____
ARE YOU CONCERNED ABOUT YOUR CHILD'S WEIGHT? Y / N

PEDIATRIC PATIENT INFORMATION

CHILD'S NAME:_____ DATE: ____/_____/____
LAST FIRST MI

FAMILY HISTORY: (Please list medical conditions that run in your family. For example: Brother: Asthma, Dad: diabetes, Aunt: sickle cell, etc…)

CONDITION(S)	LIVING?
DAD:_____	Y / N
MOM:_____	Y / N
BROTHER(S):_____	Y / N
SISTER(S):_____	Y / N

GRANDPARENTS:

DAD'S MOM:_____ Y / N DAD'S DAD:_____ Y / N
MOM'S MOM:_____ Y / N MOM'S DAD:_____ Y / N
OTHER RELATIVES:_____

SOCIAL HISTORY
WHERE AND WHOM DOES PATIENT LIVE WITH: Please include names and ages of siblings.

_____

_____

LIVES WITH A SMOKER: Y / N HOME TYPE: house, apartment, condo _____
WATER SOURCE:_____
ALWAYS WEARS HELMET WHEN BIKING/ROLLERBLADING/SKATEBORADING: Y / N
FOR CHILDREN, ALWAYS USES CAR SEAT OF BOOSTER SEAT: Y / N
FOR TEENS, ALWAYS WEARS SEATBELT: Y / N
CARBON MONOXIDE DETECTORS: Y / N
SMOKE DETECTORS ON EACH FLOOR OF HOUSEHOLD? Y / N
POOL/SPA AT HOME: Y / N
ANY PETS IN HOUSEHOLD? Y / N IF YES, WHAT KIND? _____

DEVELOPMENTAL HISTORY (if over 3 months of age)
DAYCARE/SCHOOL
ATTENDED:_____GRADE:_____
ANY DEVELOPMENTAL CONCERNS OR DIFFICULTY WITH SCHOOL? Y / N
IF YES, SPECIFY:_____

_____

AGE CHILD SAT ALONE:_____BEGAN CRAWLING:_____ BEGAN WALKING: _____
SAID FIRST WORD:_____ STOPPED NAPPING:_____ TOLIET TRAINED:_____
SLEPT THROUGH THE NIGHT:_____

SPORTS/ACTIVITIES:_____
HOW MANY HOURS A DAY DOES YOUR CHILD SPENDING:
STUDY:_____ WATCH T.V.:_____ VIDEO GAMES:_____ PHYSICALLY ACTIVE:_____
IN THE SUN:_____ WORKING:_____ WITH THE FAMILY:_____ WITH FRIENDS:_____

ANY SPORTS RELATED INJURIES? Y / N IF YES, SPECIFY:_____

PLEASE PROVIDE A COPY OF IMMUNIZATION RECORDS TO THE MEDICAL ASSISTANT.