DATE: _____ SIGNATURE: _____ PHYSICIAN

# PATIENT DEMOGRAPHIC INFORMATION

*(PLEASE PRINT)*

| | |
|---|---|
| PATIENT'S FULL NAME | MAIDEN NAME |
| ADDRESS APT. # | EMAIL<br>PHONE # ( ) |
| CITY STATE ZIP | CELL # ( )<br>WORK # ( ) |
| SEX M F MARITAL STATUS SINGLE MARRIED OTHER DIVORCED WIDOWED DATE OF BIRTH MM/DD/YY | |
| PATIENT'S EMPLOYER | |
| EMPLOYER'S ADDRESS | |
| SPOUSE'S/GUARDIAN'S NAME WORK # ( ) CELL # ( ) DATE OF BIRTH MM/DD/YY | |
| EMPLOYER ADDRESS | |
| IN CASE OF EMERGENCY CONTACT RELATIONSHIP | PHONE # ( ) |
| INSURANCE COMPANY | COPAY AMOUNT |
| NAME OF INSURED INSURED'S DOB | SELF PARENT<br>SPOUSE OTHER |
| INSURED'S EMPLOYER | |
| INSURANCE CLAIMS ADDRESS<br>CITY STATE ZIP | INSURANCE PHONE # ( ) |
| POLICY NUMBER GROUP NUMBER | |
| ANY OTHER COVERAGE? YES NO COMPANY NAME | PHONE # ( ) |
| WHOM MAY WE THANK FOR REFERRING YOU? | PRIMARY CARE PHYSICIAN |

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize White Rock Medical Clinic 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 White Rock Medical Clinic. 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.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

**ADULT PATIENT INFORMATION**

We strive to keep all information in confidence and we will not release information without signed consent. If referred, your information may be sent to consultants.

**NAME:** _____ **DATE:** _____

*LAST* *FIRST* *M.I.*

**BIRTH DATE:** _____ **AGE:** _____ **GENDER:** M / F

**MARITAL STATUS:** ( ) Single ( ) Married ( ) Widowed ( ) Separated ( ) Divorced

**OCCUPATION(S):** _____

**REASON FOR VISIT TODAY:**

**PREFERRED PHARMACY:** _____ **PHONE #:** _____

**PREVIOUS PHYSICIAN:** _____ **PHONE #:** _____

**MEDICAL CONDITION(S)/HOSPITALIZATION(S):** (Example: Diabetes, High Blood Pressure, Asthma...)

**ALLERGIES:** (Medications, food, insects...) _____

**CHILDHOOD ILLNESSES:** ( ) Chicken Pox ( ) Measles/Rubeola ( ) Mumps ( ) Rubella ( ) Scarlet Fever

**SURGERIES:** (Example: Tonsillectomy, Gallbladder, Hernia Repair...)

| **TYPE OF SURGERY** | **YEAR** |
|---|---|

**MEDICATIONS:** (List all including ones not prescribed such as alternative agents or herbal agents)

| | **DRUG** | **STRENGTH** | **HOW OFTEN YOU TAKE PER DAY** | **LENGTH OF TIME YOU HAVE TAKEN** |
|---|---|---|---|---|
| *ex.* | *Advil* | *200 mg* | *3 times per day* | *6 months* |

Please know what drugs and doses you take. If you need refills, please let the nurse know when you are placed in the exam room.

NAME: _____ DATE: _____
*LAST* *FIRST* *M.I.*

WOMEN'S HEALTH LMP

Number of Pregnancies _____
Number of Miscarriages _____
Number of Children _____
Last PAP Smear _____
Have you ever had an abnormal Pap Smear? Y / N
Last Mammogram _____
Last Bone Density Test _____
Last Colonoscopy _____

MEN'S HEALTH

Last Testicular Exam _____
Last Prostate Exam _____
Last Colonoscopy _____
Last Bone Density Test _____

Exercise Regularly? Y / N Type: _____ Times per week: _____ How Long? _____(Mins.)
Tobacco Use Currently? Y / N If yes, # of packs per day? For how many years?
Tobacco Use in the Past? Y / N If yes, when did you quit? How many years did you smoke?
Alcohol Use? Y / N If yes, # of drinks per day? Type of alcohol (ex. beer, wine)
Alcohol Use in the Past? Y / N If yes, # of drinks per day? Type of alcohol (ex. beer, wine)
Caffeine Use? Y / N How many cups per day? Number of sodas per day?
Drug Use Currently? Y / N Type of drugs (ex. Marijuana, cocaine, heroin)
Drug Use in the Past? Y / N Type of drugs (ex. Marijuana, cocaine, heroin)
Have you ever injected yourself with drugs? Y / N Do you wear your seatbelt? Y / N
Do you own a firearm? Y / N Is someone you love hurting you? Y / N

## IMMUNIZATION

Please check the box (x) next to the disease against which you have been immunized and the date of last booster. **Tetanus or Td booster is due every 10 years.** Let the nurse know if you are due for a booster.

( ) Hepatitis B Series ( ) Tetanus ( ) Meningitis Vaccine
( ) Pneumonia ( ) D.T. (Diphtheria/tetanus) ( ) Measles/Mumps/Rubella
( ) Varicella ( ) Hepatitis A Series ( ) Zoster Vaccine

**If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up-to-date with your shots.
You may benefit from Hepatitis A or B vaccine or even the Pneumonia shot.
**If you have lung disease, keep up-to-date with the Influenza and Pneumonia shots.

## FAMILY HISTORY



Please check the box (x) next to the condition that your family member has, then specify his or her relationship to you after the disease using the abbreviations as follows:

**Mother (M), Father (F), Brother (B), Sister (S), Grandparent (GP), Aunt (A), Uncle (U)**

*For example, if your Mother and Aunt both had breast cancer, write:* ***(x) Breast Cancer A.M.***

( ) Alcoholism ( ) Colon Polyps ( ) High Blood Pressure ( ) Prostate Cancer
( ) Anemia ( ) Colon Cancer ( ) Iron Disease ( ) Seizures
( ) Asthma ( ) Diabetes ( ) Kidney Disease ( ) Thyroid Disease
( ) Arthritis ( ) Glaucoma ( ) Mental Illness ( ) Tuberculosis
( ) Bleed Easy ( ) Gout ( ) Migraine
( ) Breast Cancer ( ) Heart Disease ( ) Osteoporosis

| **Living?** | **Age Now or Age at Death:** | **Current Health or Cause of Death:** |
|---|---|---|
| Father: ( ) Yes ( ) No | | |
| Mother: ( ) Yes ( ) No | | |
| Siblings: | | |

*Advance Directives: **Please discuss with your spouse or family and your physicians.***

Living Will ( ) Yes ( ) No Organ Donor ( ) Yes ( ) No Durable Power of Attorney for Health Care ( ) Yes ( ) No

# Consent for Treatment

By signing this consent, I am authorizing my physician, and/or other individuals he or she deems appropriate, to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to White Rock Medical Clinic unless revoked by me orally or in writing.

Please be informed, Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV)—the virus associated with AIDS—in any one of the following situations:

1. To screen blood, blood products, organs or tissues to determine suitability for donation.

2. If another individual is accidentally exposed to a patient's blood or body fluids, such as through a needle stick. (Any such test shall be conducted pursuant to Texas Department of State Health Services' infectious disease protocol.)

3. If a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or body fluids.

This disclosure is to inform you that you may be tested, at the expense of White Rock Medical Clinic, if any of these situations occur during your treatment period.

Patient's Printed Name _____ Date of Birth _____

Patient/Legal Representative Signature _____ Date _____

Relationship to Patient _____

Witness _____ Date _____

EPM Medical Record Number:

# FINANCIAL POLICY

Thank you for choosing White Rock Medical Clinic as your healthcare provider. We are committed to providing excellent healthcare services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. **All patients must read and sign this form prior to receiving services.**

- ✓ **It is your responsibility to provide us with your most current insurance information.**

o If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.

o We must emphasize that, as medical providers, our relationship is with you—the patient—and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and to understand the level of services covered by your insurance company.

o If you have **Medicaid** coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

o We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**

o Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

o We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

o Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

- ✓ **It is your responsibility to provide us with your most current billing information.**

o You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.

o We will send a statement to your billing address notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call us at **(972) 292-3330**.

o **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs, if applicable.

o If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs, if applicable.

o If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at White Rock Medical Clinic. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.

o In the event you submit payment by check and the bank returns the check, unpaid, for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.

o We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

- ✓ **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards.

**I have read and understand this Financial Policy.**

Signature of Responsible Party Date

Patient Name (*Print*): _____ Patient Date of Birth: _____

## Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me with a more complete description of the uses and disclosures of certain health information. I understand White Rock Medical Clinic reserves the right to change their Notice of Privacy Practices and, prior to implementation, will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or by requesting a copy in person at my appointment.

Patient's Printed Name: _____ Date of Birth: _____

Patient/Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for White Rock Medical Clinic to share my protected health information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

# IMPORTANT PATIENT INFORMATION NOTICE

## Physician Office Compliance with the Red Flag Rules

The Federal Trade Commission (FTC), in conjunction with other agencies, published the Red Flag Rules defining what a creditor and financial institution must do to implement an Identity Theft Program. The **Red Flag Rules** require those covered, including medical practices, to identify at-risk accounts and to define, detect, and respond to Red Flags in order to prevent or mitigate identity theft. Medical identity theft happens when a person seeks health care using someone else's name or insurance information.

We are committed to protecting your identity and have developed a compliance policy that will help us protect your vital personal information. Since **August 1, 2009**, our staff asks patients and/or guardians to provide the following at each appointment:

- Photo ID (Driver's License, passport or employment picture ID)
- Current insurance card
- Verification of patient demographics, including phone number and email address.

***Please Note**: No one, **including minors**, will be permitted to use a Medical Flex Card, major credit card, or make a payment by check if the patient name does not match the form of payment used - **UNLESS** we have written permission from the payer.*

*We have a form available for the person named on the card or check to complete, sign, and return to our office. The form provides permission for the specifically named patient to use that payment type for the required payments needed. This form will only need to be completed once.*

**Please remember that this is being instituted for your protection**. White Rock Medical Clinic is committed to protecting our patients through the highest level quality of care and unparalleled services.

Thank you for your assistance in helping us comply with our Identity Theft Program. If you would like a complete copy of the Red Flag Rules, please ask the receptionist and she will be happy to provide you with a copy.

*Signature Line:* _____