New Patient Packet

Date____

Family Clinic
808 W.W. Ray Circle
Bridgeport, TX. 76426

940/683-2297 phone 940/683-2722 fax

Financial Policy

Our staff would like to welcome you to our clinic and thank you for choosing us for your medical care. The following is an explanation of our financial policies.

Our clinic is contracted with several health insurance companies. Under these contracts, our office is required to file your insurance claim. To insure that you are the insured, we must have your driver's license and social security number. We are also required by our contracts to collect your co-pay or deductible at the time of service. Please be prepared to pay your responsibility. After your insurance has paid your claim and PPO or HMO discounts have been applied, any balance unpaid will be your responsibility or any overpayments will be refunded.

Our clinic will also file all Medicare claims. However, if a service is performed that is not covered under Medicare, we will inform you in advance and you will be asked to sign a form and pay for the service at that time.

Patients who are covered under a commercial insurance plan which our office is not contracted with or any 3rd. party liability insurance companies will be asked to pay in full at the time of service. Examples of 3rd party liabilities would include motor vehicle accidents, injuries at school or falls/injuries at a store.

Patients that do not have any insurance coverage will be required to pay in full at the time service.

If you feel that you cannot meet these requirements, please contact our business office for payment arrangements prior to your appointment.

We do ask that you notify our office of any changes in your insurance plan. If you have any questions regarding these policies, please feel free to speak with a representative in the business office.

Thank you for choosing the Family Clinic.

Please sign below to confirm that you;

1. Acknowledge and agree to all the terms and conditions of this policy.
2. Do hereby consent to and authorize any and all diagnostic and therapeutic treatments considered necessary or advised in judgment of the provider. All of the diagnostic and therapeutic treatments will be explained to me, and I understand that no guarantee of assurance will be made as to the results which may be obtained.
3. Authorize the release of medical treatment for the purpose of processing my claim.
4. Authorize any benefit due me be paid to Family Clinic.

X_____ X_____

Signature of Patient of Legal Representative Date

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New Patients without Insurance

Payment is required on initial office visits, which range from $149.00 to $262.00. The fee is dependent upon the actual visit and any labs, x-rays, injections, etc that are performed at the time of service.
Adjustments will be made as applicable at the end of the office visit.

New Patients with Insurance

Insurance coverage must be verified before services are provided. If for any reason we are unable to verify your insurance coverage, you will be responsible to pay in full for your office visit.

The fee is dependent upon the actual visit and any labs, x-rays, injections, etc that are performed at the time of service. Adjustments will be made as applicable at the end of the office visit.

Thank you,

Family Clinic

X_____

(Patient's Printed Name)

X_____

(Signature of Patient of Legal Representative)

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Notice of Privacy Practices Acknowledgement

I have read or received the Family Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed.

I also understand that in order to electronically prescribe medications and to secure continuity of care, I consent to have my medication history downloaded through RxHub.

X_____ _____

Patient's Printed Name — Date of Birth

X_____ _____

Signature of Patient or Legal Representative — Date

_____

Relationship to Patient

_____ _____

Witness — Date

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***** HIPAA / EMERGENCY CONTACTS *****

PATIENTS PASSCODE: ___ ___ ___ ___ (4 digits)

I authorize Family Clinic to speak/release any information to the following individuals;

1 Name:_____ DOB:_____ Phone _____

2 Name:_____ DOB:_____ Phone _____

3 Name:_____ DOB:_____ Phone _____

Patient information

Last Name_____ First Name_____ Sex_____

Date of Birth_____ Social Security _____-_____-_____ Marital Status_____

Preferred Language _____ Race_____

Address_____ City/State/Zip Code_____

Home Phone_____ Cell Phone_____

Responsible Party Information

Relationship to Patient: _____

Last Name_____ First Name_____ Sex_____

Date of Birth_____ Social Security _____-_____-_____ Marital Status_____

Preferred Language _____ Race_____

Address_____ City/State/Zip Code_____

Home Phone_____ Cell Phone_____ Employed? Y (or) N

Employer_____ Work Phone_____

Address_____ City/State/Zip Code_____

I authorize Family Clinic to mail or leave a message regarding lab/test results, appointments or reminder cards to the address or phone number that is currently on file. If unable to reach me at home, I authorize Family Clinic to leave a message at my employment to call my provider's office. This authorization will remain in effect until I give written notice to Family Clinic to the contrary.

Patient/Guardian Signature:_____ date_____

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Chronic Pain Condition

I, _____ understand that Dr. Ray, or any of his Physician Assistants will not see me for anything that has to do with my chronic pain condition.

He will refer me out to the appropriate Pain Specialist for management. I am not to ask for any refills on my pain medication at this office at any time, no exceptions.

_____ _____

Patient Signature Date

_____ _____

Witness Date

Date____

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Informed Consent to use Patient Portal

Family Clinic is offering this secure, HIPAA compliant communication tool as a courtesy to our patients. It is an optiona service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly a possible. This form is intended to inform you of the facts and risks surrounding the use of the web portal. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Family Clinic, or any of their staff liable for network infractions beyond their control.

Privacy and Security

The web portal or webpage has a secure connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or your communication to us. To help insure that it remain secure, we need to have your current (private) email address and be informed if it ever changes. Keep your portal user ID and password secure so only you, or someone authorized by you, can gain access to patient information. If you think someone has learned your password, immediately go to your portal website and change it.

Your email is confidential and protected information. With our best effort, we will protect this information as we do your medical and other personal information. We will never purposefully share this information with any third party.

All access to our internal network and our electronic medical records is password protected. Our staff are instructed to log off their workstations when not physically present.

Similar to phone communications, messages may be read and addressed by different Family Clinic staff members.

Confidential email; _____

(PLEASE PRINT CLEARLY)

Your Portal log-in will go to this address. Call us with any changes please....

Patient's Printed Name: _____ Date of Birth_____

Print name of Parent/Guardian requesting access: _____

Signature: _____ Date_____

New Patient Packet

Date_____

MEDICAL HISTORY

Patient's Name_____ Date of Birth_____

What illnesses have you had:

ADD_
ADHD_
AIDS/HIV_
Alcoholism_
Alzheimer's Disease_
Anemia Iron Deficiency_
Anemia Pernicious_
Anorexia_
Anxiety Disorder_
Aortic Disorder_
Asthma_
Bipolar_
Botulism_
Cancer, type_____
Cataracts_
Cerebrovascular accident (Stroke)_
Cervical Dysplasia (Cancer)_
Chlamydia_
Chronic Bronchitis_
Chronic Urinary Tract Infection_
Cirrhosis of the Liver_
Colitis Ulcerative_
Condyloma Warts (Genital Warts)_
Congestive Heart Failure_
Constipation_
COPD_
Depression_
Diabetes Insulin_
Diabetes Non-Insulin_
E. Coli_
Edema Swelling_
Emphysema_
Endometriosis_
Gastroenteritis_
Gerd (Acid Reflux)_
Glaucoma_
Gonorrhea_
Gout_
Headaches Migraine_
Headaches Tension_
Heart Attack_
Heart Disease_
Hemorrhoids External_
Hemorrhoids Internal_
Hep A, B or C_
Herpes Genital_
High Blood Pressure_
High Cholesterol/Triglycerides_
HPV_
Hyperthyroidism_
Hypoglycemic (Low Blood Sugar)
Hypothyroidism_
Insomnia_
Kidney Failure_
Kidney Stones_
Legionellosis_
Lyme Disease_
Malaria_
Measles_
Meningitis Bacterial_
Meningitis Viral_
Mumps_
Narcolepsy_
Neuromuscular Disease_
Osteoarthritis_
Osteoporosis_
Panic Attacks_
Parkinson's Disease_
Pertussis (Whooping Cough)_
Phlebitis (Blood Vessel Inflamed)_
Pneumonia_
Psittacosis_
Pyelonephritis (Kidney Infection)_
Reactive Airway (Asthma)_
Rheumatoid Arthritis_
Rocky Mountain Fever_
Salmonella_
Shigellosis_
Sleepwalk_
Social Phobia_
Staph Drug Resistant MRSA_
Strep A Drug Resistant_
Suicidal_
Syphilis_
Tuberculosis_
Ulcers Duodenal_
Ulcers Gastric_
Ulcers Peptic_
Urinary Incontinence_
Varicose Veins_

Other illnesses not listed: _____

What surgeries have you had: _____

How many children _____ How many step children_____ Pregnancies_____ Live Births_____

Marital Status; Married Separated Divorced Widowed Single

Tobacco Use: Type_____ Amount_____ Since_____ Quit?_____ Never Used_____

Alcohol; Nondrinker_____ Social _____ Regular Use_____ Rare_____ Experimented_____ Current or Past Alcoholic_____

Type of Alcohol; Beer Wine Malt Liquor Wine Coolers Mixed Drinks Hard Liquor

Caffeine; Coffee Tea Soda Chocolate Servings, Day_____ Week_____ Month_____

Exercise; YES NO Type:_____ Active at Work HOME

Illicit Drug Use: Current_____ Previous_____ Type:_____ Never Used

Family History,

Father: Living Yes / No cause of death_____ age_____ Illnesses _____

Mother: Living Yes /No cause of death_____ age_____ Illnesses _____

Any other relatives with illnesses that you know of:_____

_____

Have you been diagnosed with any of the following: NONE

_Anxiety Disorders (Panic Attacks, Social Phobias)
_Cognitive Disorders (Alzheimer's, Dementia)
_Gender Identity Disorder
_Obsessive Compulsive Disorder
_Eating Disorders (Anorexia, Bulimia)
_Mood Disorders (Depression, Manic)
_Impulse Control Disorder
_Schizophrenia/Psychosis
_Personality Disorder
_Sleep Disorder (Insomnia)
_Disorder starting in Childhood (learning disorder, ADD, ADHD and Mental Retardation)

Preventative Care; (Please list date of last exam)

Bone Dexa Scan_____
Mammogram_____
PSA_____
Colonoscopy_____
Pap Smear_____
Wellness Annual Exam_____

Date____

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Patient's Name_____ **Date of birth**_____

List All Medications **dosage (mg)** **Taken**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy:_____

Any Allergies; Y / N

_____

_____

_____