

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 _____
Signature of Patient of Legal Representative

X _____
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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Patient information

Last Name _____ FirstName _____

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 _____ FirstName _____

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 _____

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HIPAA

I DO NOT authorize Family Clinic to speak or release any paperwork to the following individuals;

***(or)**

I DO authorize Family Clinic to speak or release any paperwork to the following individuals ONLY:

Please circle the preferred method of contact;

phone, mail or email; _____

EMERGENCY CONTACTS

1. Name: _____ DOB _____

Phone: _____ relationship: _____

2. Name: _____ DOB _____

Phone: _____ relationship: _____

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

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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 optional service, and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly as 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 remains 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 _____