Corinth Family Medicine & Pediatrics

Date: _____ Age: _____ Sex: M F Date of Birth: _____ Time of Birth:_____ AM PM

Patient's Name: _____
Last First Middle

Street address: _____

City, State, Zip _____

Phone Number: _____ _____
Best Contact Number Second Best Contact Number

Email Address: _____ Patient Portal Access: Yes No

Do you have other family members seen in our office?

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

How did you hear about our office? _____

Name of school patient attends: _____

Biological Parent Information (Both sections *MUST* be filled out completely.)

Patient's Parents: (Circle One) Married Separated Divorced w/o restrictions Divorced w/ restrictions Widowed

Father's Name: _____ Mother's Name: _____

Date of Birth: _____ SS# _____ Date of Birth: _____ SS# _____

Street Address: _____ Street Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone Number: H_____ C _____ Phone Number: H_____ C _____

Employer: _____ Tel:_____ Employer: _____ Tel:_____

Emergency Contact (NOT BIOLOGICAL PARENT)

Name: _____ Relation to Patient: _____

Phone Number: _____ _____ _____
Home Work Cell

Street Address: _____ City, State, Zip: _____

Second Emergency Contact (NOT BIOLOGICAL PARENT) *(Must be someone **not** living in your home; relative, neighbor, friend, etc.)*

Name: _____ Relation to Patient: _____

Phone Number: _____ _____ _____
Home Work Cell

Street Address: _____ City, State, Zip: _____

Primary Insurance Information

Name of Insurance Company: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relation to Patient: _____

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Family Medicine

Karri Dutton, MD
Kristen McNiel, APRN-CNP
Pediatrics

Corinth Family Medicine and Pediatrics
Privacy Practices, Financial Policy, and Consent for Treatment

1) I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I have also reviewed this office's Financial Policy, which explains my responsibilities related to payment for services performed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices and/or Financial Policy at my request. I consent to evaluation and treatment for myself or my child by the medical staff at *Corinth Family Medicine & Pediatrics* and their ancillaries.

_____
Name of Patient (Print)

_____
Signature of Patient/Legal Guardian

_____
Relationship of Patient Representative to Patient
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Date

Optional:
2) My child _____ is between the ages of **14 and 18 years old**. He/She may be evaluated and/or treated by the staff at *Corinth Family Medicine & Pediatrics* without my presence of notification. I understand I will be notified of any serious medical condition by phone (as determined by the medical staff) and have provided appropriate contact information. Certain medical information may be considered confidential according to Texas State Law. This specific information will not be provided to parents without the adolescent's expressed consent. Parents may request a copy of their child's medical records at any time. I understand that my insurance will be billed or I will be responsible to pay for any services provided per the office Financial Policy.

_____ _____
Patient/Guardian Signature Date

"Family Treating Families"

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Pediatrics

Patient Name: _____ **DOB:** _____

Dear Patients:

If your appointment is for a WELL PATIENT EXAM it will be billed as such to your insurance plan. Insurance companies may call this a PREVENTATIVE CARE or ROUTINE EXAM.

_____ ***(initial)*** Due to coding laws, we MUST bill your WELL PATIENT EXAM as Preventative Care. **If, during your visit you have ADDITIONAL CONCERNS or PROBLEMS that require a diagnosis and/or treatment, it would be considered a Problem Oriented Exam and you may incur additional office or lab charges**. These charges and any from your Preventative Care Exam will be billed to your insurance company. You and your physician may want to keep your Well Exam separate from your Problem-Oriented Exam and we would be happy to schedule it that way for you.

_____ ***(initial)*** If your insurance company does not cover some or all of these charges, you will be billed directly for the balance they indicate as "patient responsibility."

_____ ***(initial)*** Please DO NOT ASK US TO RE-BILL your insurance by changing the procedure codes or diagnosis codes. We are unable to make a change once the insurance has been billed for a Well Exam.

_____ ***(initial)*** Almost all insurance plans now cover well exams at 100% without copay or deductible, but will not do so if problems are addressed. Well Exams are important whether it is a covered benefit or not. Please take the time to make yourself familiar with your insurance benefits. Feel free to call the insurance company and ask about coverage. There are many plans and your benefits can change often.

_____ ***(initial)*** NOTE: Certain tests we order as part of your Well Patient Exam may or may not be covered by your insurance. This includes, but is not limited to: blood work, lab tests, audiometry (hearing tests), vision screening, and x-rays. We make every effort to order only prevention services recommended by the US Prevention Task Force and therefore covered by insurance.

We appreciate your understanding and cooperation.

_____ _____

Patient/Parent/Legal Guardian Signature **Date**

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Thank you for choosing Corinth *Family Medicine & Pediatrics*. We are committed to providing you with the highest standards of medical care. In order to achieve this goal, we need your assistance and understanding of our financial policy.

Payment for services is due at the time of service unless arrangements have been made in advance by your health plan. We accept cash, check, Visa and MasterCard. If a check is returned for NSF there will be a $25.00 fee and we will no longer be able to accept your personal checks.

Insurance

- _____ ***(initial)*** Please keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you we will file your insurance claim if you assign the benefits to the doctor***. It is your responsibility to know your health care plan and coverage.***
- _____ ***(initial)*** We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payments, co-insurance, deductible. This amount represents our best estimate based on information from your insurance carrier and payment will be due at the time of service.
- _____ ***(initial)*** Please present your insurance card at each visit. Specifically, bring to our attention any changes (new card, new group #, etc) since your last visit. You will be responsible for any bill that was not paid by your insurance carrier due to incorrect information. If you do not have your insurance information, we will still see you, however payment in full will be required at the time of service.
- _____ ***(initial)*** If you have insurance coverage with a plan for which we do not have a prior agreement the charges for your care and treatment are due at the time of service.
- _____ ***(initial)*** In the event that your health plan determines a service to be "not covered" you will be responsible for the negotiated rate of service performed. Payment is due upon receipt of a statement from our office.
- _____ ***(initial)*** You should be aware that you may receive an additional bill from a separate entity/laboratory for any testing/labs done in our office.

Minor Patients:

- _____ ***(initial)*** The adult accompanying a minor patient will be responsible for services rendered.

Missed Appointment.:

- _____ ***(initial)*** In order to allow time for same day sick visits we ask that you provide our office ***a 24-hour notice prior to canceling or rescheduling an appointment.*** In the event you fail to cancel a scheduled appointment at least 24 hours in advance of that appointment time you will be considered "No Show" and may be billed a fee of $50.00 which is due upon receipt from this office. **If there are 3 or more "No Show" visits no further appointments will be scheduled and the patient may be asked to seek future medical care elsewhere.**

Payment/Late Charges:

- _____ ***(initial)*** Fees are due and payable on the date services are rendered and patient or parent is expected to pay all such charges incurred in full immediately upon presentation of the appropriate statement. Any balance remaining 30 days after date of statement will be charged to the credit card on file for the patient and a receipt of these charges will be mailed to the person named on the card. If no credit card is on file monthly statements will be mailed to responsible party at address on file. ***All charges will incur a 10% late fee each month until paid in full.*** Unpaid balances more than 90 days past due may be turned over to collections and the billed party will be responsible for any fees associated with this collection process. Prior balances are due at time of service.

Patient Name: _____ **DOB**: _____

Patient/Guardian Signature: _____ **Date**: _____

Corinth Family Medicine & Pediatrics

Financial Arrangements & Insurance Agreement

Consent for Service/Release of Information:

- _____ ***(initial)*** I request, authorize and give consent for *Corinth Family Medicine & Pediatrics* to provide treatments and services. By making this request, I become fully responsible for any and all charges incurred in the course of this treatment.
- _____ ***(initial)*** I authorize *Corinth Family Medicine & Pediatrics* to (1) release information necessary to insurance carriers regarding my illness and treatments and that of my dependents, (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Assignments of Benefits:

- _____ ***(initial)*** I hereby assign all medical and surgical benefits to which I am entitled. I authorize and direct my insurance carrier(s) to issue payment checks directly to *Corinth Family Medicine & Pediatrics* for services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Requests for Medical Records:

- _____ ***(initial)*** In accordance with Texas law, *Corinth Family Medicine & Pediatrics* requires written request for the release of medical records. Texas law allows 15 business days to fulfill this request, so please take this into consideration when requesting copies of medical records. There may be a fee required for the processing of this request.

Credit Card Authorization (optional):

- _____ ***(initial)*** I authorize *Corinth Family Medicine & Pediatrics* to charge any outstanding balances on my account to the credit card below. I understand that I will be mailed a statement of outstanding charges before and a receipt of the charges after the card is charged. It is my responsibility to update all demographic information.

A photocopy of this assignment/agreement is to be considered as valid as the original. I also understand and agree that the practice may amend such terms from time to time. At any time, I may request a copy of the current financial policy and may revoke this agreement with written statement and agreement to the alternative of service and/or discontinuation of care.

Type of Card: MasterCard Visa Is this a health savings card? Yes No

Name on card: _____

Card Number: _____

Expiration Date: _____

Billing Address: _____

Patient Name: _____ **DOB**: _____

Patient/Guardian Signature: _____ **Date**:_____

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CORINTH Family Medicine and Pediatrics

Patient Name _____ **Date of Birth** _____

In compliance with federal and state law *Corinth Family Medicine & Pediatrics* will not discuss any private patient information including lab or test results with anyone other than the patient or parent/legal guardian of a minor patient unless permission is given in advance.

I authorize *Corinth Family Medicine & Pediatrics* to provide my private medical information including diagnosis, treatment, lab and test results to the following person if requested or deemed necessary by my physician.

Name _____ Relationship _____ Phone Number _____

Federal and state privacy laws also require *Corinth Family Medicine & Pediatrics* to obtain prior written consent to leave medical information on a patient's voicemail. If we are unable to reach you by phone, **you may give permission for us to leave a detailed message by initialing below**. This message may include diagnosis, treatment, test results, and discussion of other medical issues.

Option 1. _____ If unable to reach me by phone, I consent to *Corinth Family Medicine & Pediatrics* to leave a detailed message on the voicemail at the following number:

_____
Phone Number

Option 2. _____ Please leave only the following message on voicemail at numbers listed in my chart if needed. (No medical information will be left on voicemail.)

"This is _____ calling from Corinth Family Medicine & Pediatrics. Please call our office at 940-497-4900 as soon as possible/at your convenience. Thank you."

Patient/Guardian Signature _____ **Date** _____

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Name of Patient _____

Patient Date of Birth _____

Street Address _____

City, State, ZIP Code _____

AUTHORIZES:

_____
Name of Physician

_____
Name of Health Care Facility

_____
City, State, Zip Code

_____
Phone Number/Fax Number

RELEASE OF RECORDS TO:

Corinth Family Medicine & Pediatrics

3001 FM 2181, Suite 300

Corinth, TX 76210

Please fax to 855-978-2330 or mail.
(Please Do Not Send CD)

INFORMATION TO BE RELEASED:

□ All Clinic Records □ Lab Reports □ Photographs/X-Ray Reports
□ ER Records □ Immunization Records
□ Other (Specify) _____
For the following dates of service: _____ □ All dates of service

PURPOSE OR NEED FOR DISCLOSURE:

□ Further Medical Care □ Payment of Insurance Claim □ Legal Investigation
□ Application for Insurance □ Disability Determination □ Other _____

I understand that this authorization shall be valid for one (1) year or until the date stated below or revoked through written notice to Medical Records. _____ (do not put today's date)
Date

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

SIGNATURE OF PATIENT _____ **DATE** _____
(If over 18 years of age)
SIGNATURE OF PARENT/ GUARDIAN_____**DATE**_01/30/2023____

Print Name _____
Patient is: □ Minor □ Incompetent □ Disabled □ Deceased
Legal Authority: □ Legal □ Legal Guardian □ Next of Kin of Deceased