



**Patient Information Form**

**1. PATIENT INFORMATION:**

PATIENT NAME: LAST FIRST MIDDLE

PREFERRED NAME/ NICKNAME SOCIAL SECURITY# DATE OF BIRTH MM/DD/YYYY

SEX: M F MARITAL STATUS EMAIL ADDRESS

MAILING ADDRESS: DRIVER LICENSE#

CITY STATE ZIP

IS THIS A WORK RELATED INCIDENT? YES NO PRIMARY CARE PHYSICIAN:

**RACE:**  
 \_\_\_ ASIAN OR PACIFIC ISLANDER \_\_\_ HISPANIC  
 \_\_\_ BLACK OR AFRICAN AMERICAN \_\_\_ WHITE  
 \_\_\_ OTHER: \_\_\_\_\_  
 \_\_\_ PREFER NOT TO PROVIDE RACE/ETHNICITY

**ETHNICITY:**  
 \_\_\_ HISPANIC OR LATINO  
 \_\_\_ NOT HISPANIC OR LATINO

**PATIENT PREFERRED LANGUAGE:**  
 \_\_\_ ENGLISH  
 \_\_\_ SPANISH  
 \_\_\_ OTHER: \_\_\_\_\_

**2. EMERGENCY CONTACT INFORMATION:**

NAME RELATIONSHIP EMERGENCY CONTACT PHONE ( )

**3. GUARANTOR INFORMATION:** Patients under 18 need a Guarantor (who is responsible for the bills and where they will be sent)

NAME DATE OF BIRTH MM/DD/YYYY SOCIAL SECURITY#

RELATIONSHIP TO PATIENT GUARANTOR ADDRESS GUARANTOR EMPLOYER

**4. COMMUNICATION AUTHORIZATION:**

		PHONE NUMBER		
		OK TO LEAVE A DETAILED MESSAGE		
		YES	OR	NO
Cell Phone				
Cell Phone Carrier:	<input type="checkbox"/> Verizon <input type="checkbox"/> Cellular One <input type="checkbox"/> T-Mobile <input type="checkbox"/> Sprint <input type="checkbox"/> AT&T <input type="checkbox"/> Cricket Wireless <input type="checkbox"/> Other : _____	<input type="checkbox"/>		<input type="checkbox"/>
Home Phone		<input type="checkbox"/>		<input type="checkbox"/>
Day Phone		<input type="checkbox"/>		<input type="checkbox"/>
Guarantor Phone		<input type="checkbox"/>		<input type="checkbox"/>

**WOULD YOU LIKE TO RECEIVE TEXT MESSAGE REMINDERS\*** \_\_\_\_\_ YES \_\_\_\_\_ NO

\*Text messages sent through unsecured message- we will not send any personal information through text message. Message and data rates may apply.

PREFERRED TO BE CONTACTED BY: \_\_\_ Cell \_\_\_ Home \_\_\_ Day \_\_\_ Patient Portal \_\_\_ Email

**5. WHAT PHARMACY(S) DO YOU USE:** 1) \_\_\_\_\_ 2) \_\_\_\_\_

X \_\_\_\_\_  
 Signature of Patient or Legally Responsible Party Relationship to Patient Date





**Adult Health History Form - Continued**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_ Provider: \_\_\_\_\_

**5. Past Surgical History**

- |  | Year  |   | Year  |
|--|-------|---|-------|
| <input type="checkbox"/> Angioplasty           | _____ | <input type="checkbox"/> Colectomy        | _____ |
| <input type="checkbox"/> Angio w/stent         | _____ | <input type="checkbox"/> Colostomy        | _____ |
| <input type="checkbox"/> Appendectomy          | _____ | <input type="checkbox"/> Gastric Bypass   | _____ |
| <input type="checkbox"/> Arthroscopy: _____    | _____ | <input type="checkbox"/> Hernia Repair    | _____ |
| <input type="checkbox"/> Back Surgery          | _____ | <input type="checkbox"/> Hip Replacement  | _____ |
| <input type="checkbox"/> Blood Transfusion     | _____ | <input type="checkbox"/> Knee Replacement | _____ |
| <input type="checkbox"/> CABG                  | _____ | <input type="checkbox"/> LASIK            | _____ |
| <input type="checkbox"/> Cardiac Pacemaker     | _____ | <input type="checkbox"/> ORIF             | _____ |
| <input type="checkbox"/> Carpal Tunnel Release | _____ | <input type="checkbox"/> Thyroidectomy    | _____ |
| <input type="checkbox"/> Cataract Extraction   | _____ | <input type="checkbox"/> Tonsillectomy    | _____ |
| <input type="checkbox"/> Cholecystectomy       | _____ | <input type="checkbox"/> Other            | _____ |

Please include C-Section \_\_\_\_\_

**6. Past Diagnostic History**

Bone Density: Date \_\_\_\_\_ Date \_\_\_\_\_ Colonoscopy: Date \_\_\_\_\_ Date \_\_\_\_\_  
 Mammogram: Date \_\_\_\_\_ Date \_\_\_\_\_ PSA and Result: Date \_\_\_\_\_ Date \_\_\_\_\_

**7. Family History**

	Diseases	Onset Age
Father: _____		_____
Mother: _____		_____
Siblings: _____		_____
_____		_____
_____		_____
Paternal Grandfather: _____		_____
Paternal Grandmother: _____		_____
Maternal Grandfather: _____		_____
Maternal Grandmother: _____		_____
Spouse: _____		_____
Children: _____		_____

**8. Your Social History**

Tobacco use: No Yes  
 Type \_\_\_\_\_  
 Amount per day \_\_\_\_\_

Caffeine use: No Yes  
 Type \_\_\_\_\_  
 Amount per day \_\_\_\_\_

Alcohol use: No Yes  
 Type \_\_\_\_\_  
 Amount per day \_\_\_\_\_

Have you or anyone in the home been subjected to neglect, physical, sexual, emotional or other abuse? If yes, what type, when, treatment, etc. \_\_\_\_\_.

Have you or anyone in the home been subjected to domestic violence? If yes, explain \_\_\_\_\_.

**9. Wellness History**

Flu Shot Date: \_\_\_\_\_ Pneumonia Shot Date: \_\_\_\_\_ Tetanus Shot Date: \_\_\_\_\_  
 Birth Control Method: \_\_\_\_\_ Last Pap-smear Date: \_\_\_\_\_ Previous Abnormal Pap: Yes No  
 Age started menstruating: \_\_\_\_\_ Date of Last Period: \_\_\_\_\_ Interval between periods: \_\_\_\_\_  
 Flow: Light Normal Heavy Pain with periods: Yes No Age menopause began: \_\_\_\_\_  
 Number of pregnancies: \_\_\_\_\_ Number of Children: \_\_\_\_\_ Number of abortions: \_\_\_\_\_ Number of Miscarriages: \_\_\_\_\_

X \_\_\_\_\_  
 Signature of Patient or Legally Responsible Party Relationship to Patient Date



**Financial Policy**

Thank you for choosing Stephenville Medical & Surgical Clinic (SMSC), and/or Community Health Clinic (CHC), and/or Eye Care Consultants (ECC), for your health care needs. We are committed to delivering outstanding health care services to you, our patient. As a part of our professional relationship, it is important that you understand our financial policy.

**All patients must read & 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 are 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 understand the level of services covered by your insurance company.
  - o We may accept assignment of insurance after verification of your coverage. Please be aware that your insurance company may not fully cover some, or perhaps all, of the services provided. **You are financially responsible for services not considered a benefit by your insurance company.**
  - o Before receiving services, verify we are participating providers for your insurance plan. 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 Copayments, coinsurance and/or deductibles are due at the time of service. We may estimate the amount you owe based on information we received from your insurance company. You are responsible for paying the full amount determined by your insurance company after your claim is processed – **regardless of our estimation.**
  - o If you do not have insurance, a discount for professional services may be given if 1) your balance is paid in full on the day services are rendered and 2) there is no outstanding balance on your account. Discount does not apply if payment method is CareCredit.
- **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 other contact information. **If your address or contact information changes, it is your responsibility to provide updated information.**
  - o We will send a statement (to the billing address you provide) notifying you of balances owed. If you have any questions or dispute the validity of the balances, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You may call 254-968-6051 ext. 4204.
  - 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.
  - o If you are not able to pay the balance due in full, 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 In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add \$30.00 to your original balance. In addition, we may seek additional legal remedies provided to us under Texas law.
  - o **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

**Full payment is due at time of service. We accept cash, check (with appropriate ID), debit/credit card, & CareCredit. I have read and understand this Financial Policy.**

X \_\_\_\_\_  
**Signature of Patient or Legally Responsible Party**                      **Relationship to Patient**                      **Date**

\_\_\_\_\_                      \_\_\_\_\_  
**Patient Name (Printed)**                      **Patient Date of Birth**



**HIPAA Authorization for Release of Patient Health Information**

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- Home or Cell Phone: \_\_\_\_\_
  - OK to leave a message with detailed information
  - Leave name and doctor with call back number only
- Work Telephone: \_\_\_\_\_
  - OK to leave message with detailed information
  - Leave name & doctor with call back number only
- When unable to contact me by phone, a written communication may be sent to my home address.
- Other: \_\_\_\_\_

I consent and authorize the release of Medical Information to the following:

- Only Myself
- Telephone Answering Machine/Voice Mail
- My Spouse: \_\_\_\_\_
- My Children: \_\_\_\_\_
- My Parents: \_\_\_\_\_
- Other: \_\_\_\_\_

I consent and authorize the release of Financial Information to the following:

- Only Myself
- Telephone Answering Machine/Voice Mail
- My Spouse: \_\_\_\_\_
- My Children: \_\_\_\_\_
- My Parents: \_\_\_\_\_
- Other: \_\_\_\_\_

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- Yes       No

Do you have an advanced directive (Living Will)?

- Yes       No

I consent and authorize your office or facility to make calls and/or send text messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.

- Yes       No

\_\_\_\_\_  
Patient/Guardian Signature (Must be an adult 18 years or older.)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Birthdate



**Authorizations, Forms, and Consents**

**CONSENT TO TREATMENT:** I, the undersigned, as the patient (or on behalf of the patient) do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the practitioner on duty. I understand that no guarantee or assurance has been made as to the results that may be obtained.

**ASSIGNMENT OF BENEFITS:** I hereby authorize that any benefits or fees payable to me by any insurance companies be paid directly to the Stephenville Medical & Surgical Clinic, PA, Community Health Clinic, LLP, Eye Care Consultants and/or any ancillary providers. I understand that this order does not relieve me of my obligation to pay the account. I understand that I am responsible for health insurance deductibles and coinsurance.

**ACCESS TO MEDICAL INFORMATION:** I give consent to release, permit access to, or inspection of my medical records by my Health Plan, State and Federal regulatory authorities and/or their authorized representatives. I further consent and authorize Stephenville Medical & Surgical Clinic, PA, Community Health Clinic, LLP, and Eye Care Consultants to release or review my medical record as necessary for determination or collection of insurance benefits and/or in the performance of quality review, maintaining measures of confidentiality and security.

**MEDICARE & MEDICAID BENEFICIARIES ONLY:** I certify that the information given in applying for payment under Title XVIII of the Social Security Act and/or Title XIX is correct. I authorize the release of all records required to act on this request so that payment of authorized benefits be made to Stephenville Medical & Surgical Clinic, PA and/or Community Health Clinic, LLP and/or Eye Care Consultants.

**I HAVE READ THE AUTHORIZATIONS, CONSENTS AND AGREEMENTS, AND I ACCEPT THE TERMS AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED IN WRITING BY THE PATIENT.**

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient Date of birth**

**X** \_\_\_\_\_  
**Patient /Legal Representative Signature**

\_\_\_\_\_  
**Todays Date**

_____ SMSC/CHC/ECC Employee
_____ Employee Name (Printed)



**Consent for Treatment**

By signing this consent, I am authorizing my physician(s) and/or another person to perform all exams, tests, procedures, injections, phlebotomy, 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 Privia Medical Group North Texas, Stephenville Medical & Surgical Clinic, Community Health Clinic, or Eye Care Consultants unless revoked by me in writing.

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Patient/Legal Representative Signature**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Legal Representative Name (print)**



**Acknowledgment of Review of  
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
**Patient Name (Print)**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Patient/Legal Representative Signature**

\_\_\_\_\_  
**Today's Date**

\_\_\_\_\_  
**Legal Representative Name (print)**



## **NextMD Patient Portal**

Once enrolled in the Patient Portal, go to [www.nextmd.com](http://www.nextmd.com) to:

- Request appointments
- Receive documents
  - Lab results, immunization records, office visit summaries, and more
- View your statement
- Make a payment
- Request medication refills
- Search for credible health information
- Send and receive secure messages to and from your provider
- Complete forms
- Complete and view Instant Medical History forms
- View your Personal Health Record (PHR)
- Update account information
- Sign up with multiple practices

### **User Information**

Parents may add children up to the age of 17.

At 18, the patient must complete their own enrollment, and access will only be given to the parent under the patient's written authorization.

Spouses, guarantors, and caregivers must have written authorization from the patient or legal proof of guardianship, proxy, or other in order to access patient information.

Varying levels of access can be granted including the ability to view/schedule:

- Appointments
- Documents
- Statements
- Medications
- Messages
- Online Forms
- Interactive Medical Forms

Individuals may wish for parents, spouses, or others to only have restricted access privileges.

Portal questions, or to enroll over the phone, call 254-968-6051 ext. 4284.