Stephenville Medical & Surgical Clinic
Proud Member of Privia Medical Group
Community Health Clinic
Eye Care Consultants

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:	☐Verizon ☐Cellular One ☐T-Mobile ☐ Sprint ☐AT&T ☐Cricket Wireless ☐Other : _____	☐ ☐
Home Phone		☐ ☐
Day Phone		☐ ☐
Guarantor Phone		☐ ☐

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**

Revised 3/10; 1/11; 6/11; 6/13; 7/18;1/19; 12/19; 2/20

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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.**
  - 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.
  - 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.
  - 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.**
  - 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.
  - 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**.
  - 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.**
  - 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.**
  - 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.
  - **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.
  - 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.**
  - 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.
  - **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**

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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)

Eye Care Consultants

Personal Medical History

Name: _____ **Date of Birth:**____/____/____

Reason for Visit:_____

Affected Eye:_____

Duration:_____

Onset: ☐ Gradual ☐ Sudden ☐ Recent

☐ Light Sensitivity

☐ Pain

☐ Decreased Vision

Ocular Conditions

	Affected Eye			Date/Year	
	Right	**Left**	**Both**	**Diagnosed**	**Medications/Treatment**
☐ Glaucoma	☐	☐	☐	_____	_____
☐ Cataract	☐	☐	☐	_____	_____
☐ Macular Degeneration	☐	☐	☐	_____	_____
☐ Diabetic Retinopathy	☐	☐	☐	_____	_____
☐ Dry Eyes	☐	☐	☐	_____	_____
☐ Conjunctivitis	☐	☐	☐	_____	_____
☐ Strabismus	☐	☐	☐	_____	_____
☐ Amblyopia	☐	☐	☐	_____	_____
☐ Traumatic Injury	☐	☐	☐	_____	_____
☐ Retinal Detachment	☐	☐	☐	_____	_____
☐ Other	☐	☐	☐	_____	_____

Patient's Chronic Conditions

☐ Diabetes
☐ Hypertension
☐ Rheumatoid Arthritis
☐ Hyperlipidemia
☐ COPD
☐ Asthma
☐ Bleeding Disorder
☐ HIV
☐ Hepatitis C
☐ Heart Disease
☐ Stroke
☐ Anxiety
☐ Migraines
☐ BPH
☐ Other

Family History

☐ Amblyopia
☐ Blindness
☐ Cataracts
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Disorder
☐ Strabismus
☐ Other
☐ Hypertension
☐ Diabetes
☐ Heart Disease
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Respiratory Disease
☐ Circulatory Disorders

Males Only

Are you currently taking any medications for your prostate? If yes, name of medications _____

Females Only

Date of Last Menstrual Period ___ /___ /___ Could you be pregnant? ☐ Yes ☐ No

Past Medical History

☐ Allergies	☐ Blood Clots	☐ Gallbladder Disease	☐ Myocardial Infarction
☐ Anemia	☐ Cancer	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ Cerebrovascular Accident	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ COPD	☐ Hyperlipidemia	☐ Peptic Ulcer Disease
☐ Arthritis	☐ Coronary Artery Disease	☐ Hypertension	☐ Renal Disease
☐ Asthma	☐ Crohn's Disease	☐ Irritable Bowel Disease	☐ Seizure Disorder
☐ Atrial Fibrillation	☐ Depression	☐ Liver Disease	☐ Thyroid Disease
☐ Benign Prostatic Hypertrophy	☐ Diabetes	☐ Migraine Headaches	☐ Other:_____

Past Surgical History

	Year		Year
☐ Angioplasty	_____	☐ Gastric Bypass	_____
☐ Angio w/stent	_____	☐ Hernia Repair	_____
☐ Appendectomy	_____	☐ Hip Replacement	_____
☐ Arthroscopy Knee	_____	☐ Knee Replacement	_____
☐ Back Surgery	_____	☐ LASIK	_____
☐ CABG	_____	☐ Liver Biopsy	_____
☐ Carpal Tunnel Release	_____	☐ ORIF	_____
☐ Cataract Extraction	_____	☐ Pacemaker	_____
☐ Cholecystectomy	_____	☐ Small Bowel Resection	_____
☐ Colectomy	_____	☐ Thyroidectomy	_____
☐ Colostomy	_____	☐ Tonsillectomy	_____
☐ Other	_____		

Social History

Drug Use
☐ Yes ☐ No Type: _____

Alcohol Use
☐ Yes ☐ No Amount Daily: _____

Tobacco Use
☐ Yes ☐ No Type: _____ Amount a day _____

Caffeine Use
☐ Yes ☐ No Amount Daily:_____

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_____

Review of Present Medical Conditions

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Fever	☐	☐	Cough	☐	☐	Diarrhea	☐	☐	Headache	☐	☐	Easy Bleeding
☐	☐	Weight Loss	☐	☐	Dyspnea	☐	☐	Polyuria	☐	☐	Dizziness	☐	☐	Frequent Infections
☐	☐	Sore Throat	☐	☐	Snoring	☐	☐	Heat Intolerance	☐	☐	Weakness	☐	☐	Blood Thinner Use
☐	☐	Fatigue	☐	☐	Chest Pain	☐	☐	Cold Intolerance	☐	☐	Joint Pain	☐	☐	Seasonal Allergies
☐	☐	Hearing Loss	☐	☐	Irr. Heartbeat	☐	☐	Anxiety	☐	☐	Joint Swelling	☐	☐	Immune Deficiency
☐	☐	Sinus Problems	☐	☐	Nausea	☐	☐	Depression	☐	☐	Rash	☐	☐	Prostate Med Use
☐	☐	Weight Gain	☐	☐	Vomiting	☐	☐	Stress	☐	☐	Anemia			

Current Medication List: Please list ALL medications: prescription, over-the-counter, herbal, supplements, etc.

DRUG	STRENGTH	HOW OFTEN	LENGTH OF TIME TAKEN
Example: Advil	200 mg	3 times a day	6 months

Allergies: **Reaction:** **Onset Date:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ No known allergies