Family Practice Associates, LCC

4206 Call Field Road, Wichita Falls, TX 76308 940-397-5200

NEW PATIENT REGISTRATION FORM

(Please complete this form in its entirety.)

Date: ____________
Last Name: ____________________ First Name: _____________________ Middle Initial: ___
Date of Birth: ____/_____/______ Age: ____ Gender: ☐ Male ☐ Female
SS#: _______-_______-__________
Address: _______________________ City: _____________ State: _____ Zip Code: _________
Phone: _______________________ Email: ____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Emergency Contact Name and Phone: ____
Patient's Employer: _____________________________ Work #: ________________________

GUARANTOR INFORMATION

(Please list name of insured person responsible for billing purposes)

☐ Self (Same as above)
OR
Relationship of Guarantor to Client: ☐ Spouse ☐ Parent/Guardian ☐ Other
Last Name: _______________________ First Name: ___________________ Middle Initial: ___
Date of Birth: ____/_____/_______ Age: ____ SS#: ______-______-_________ Gender: _____
Address: _______________________ City: _____________ State: _______ Zip Code: _______
Phone: _____________________ Email: ____
Employer: ____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name: ________________________________ Phone: _________________
Insured's Name: ____________________________ Insured's SSN: _______-_____-_________
Insured's Place of Employment: ____
Type of Plan: HMO ☐ PPO ☐ POS ☐ EPO ☐ Other: _________________________________
Policy ID Number: _______________ Group Number: ___________ Effective Date: _________

SECONDARY INSURANCE

Insurance Company Name: ________________________________ Phone: _________________
Insured's Name: ____________________________ Insured's SSN: _______-_____-_________
Insured's Place of Employment: ____
Type of Plan: HMO ☐ PPO ☐ POS ☐ EPO ☐ Other: _________________________________
Policy ID Number: _______________ Group Number: ___________ Effective Date: _________

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PERSONAL REPRESENTATIVES FORM

Direct communication between the client (patient) and the healthcare team is the preferred situation. However, we understand that there are circumstances in which our clients would like to appoint another individual to represent them. This form identifies a person(s) whom the client has chosen to act on the client's behalf regarding communications with this office. Please understand that this form is optional. If this form is not filled out and signed, our office will communicate with the client only.

By completing this form, you are allowing the following individual(s) to call this office for questions regarding your health and the status of tests, medications/prescriptions, orders, referrals, and documents/records.

Personal Representative 1: ____

Relationship to Client: ____________________ Phone: ________________________________

Personal Representative 2: ____

Relationship to Client: ____________________ Phone: ________________________________

Personal Representative 3: ____

Relationship to Client: ____________________ Phone: ________________________________

Printed Name of Client/Guarantor: ______________________________DOB: _____________

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Client/Guarantor Signature: ____ Date: ________

Client Name and DOB *(if other)*: ____

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY AND OFFICE POLICIES AND PRCEDURES

I, ______________________________________, am the responsible party for the account with Family Practice Associates for the client listed below. I acknowledge and agree to the following and will adhere to the policies set forth regarding this account.

- If the insurance requires a copay for services at the time of appointment, I agree to pay this co-pay upon arrival of appointment time. I understand that failure to do so can result in cancellation and/or rescheduling of that appointment.
- I agree to pay any portion of billing that the insurance does not cover or allow for any reason.
- I agree to make a payment toward the outstanding balance on the account(s) at least once per calendar month. If I cannot pay the balance in full, I agree to set up and adhere to payment arrangements. *(Copays for office visits are not considered a monthly payment.)*
- I will notify the facility immediately of any changes to the insurance(s) and/or billing address and related information.
- Family Practice Associates sends out statements every 30 days. If there is a dispute within the statement, I will contact the business office before the next billing cycle (within 30 days) regarding the dispute.
- If insurance denies a claim, I understand that it is my responsibility to pay any remaining balance.
- I understand that failure to adhere to the financial agreement in place may result in rescheduling of future appointments or dismissal from care.
- I understand and have received a copy of the office policies and procedures.
- All of my questions have been answered.

Printed Name of Client/Guarantor: ________________________________DOB: _____________

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Client/Guarantor Signature: ____ Date: ________

Client Name and DOB *(if other)*: ____

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GENERAL CONSENT FOR CARE AND TREATMENT

This consent form provides Family Practice Associates with the permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

By signing this consent, you also agree to be contacted via phone, text, or email. You also consent to the disclosure of information necessary to support any claims for health insurance benefits and medical information deemed appropriate by Family Practice Associates staff.

You have the right to discuss the treatment plan with your healthcare provider regarding the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I, ___________________________________, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name of Client/Guarantor: _________________________________DOB: ______________

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Client/Guarantor Signature: ____ Date: ________

Client Name and DOB *(if other):* ____

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NOTICE OF PRIVACY PRACTICES

It is required by law that we, Family Practice Associates, maintain the privacy of our patients regarding the protection of health information. Our Notice of Privacy Practices is available upon request in written form.

I, ________________________________, acknowledge that the Notice of Privacy Practices was made available to me and I understand that I am entitled to a paper copy of this document upon request.

Printed Name of Client/Guarantor: ______________________________DOB: ____________

Relationship to Client: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

Client/Guarantor Signature: ____ Date: ________

Client Name and DOB *(if other):* ____

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GENERAL INFORMATION

- Clients under the age of 18 must be accompanied by an adult.
- Our main line (940-397-5200) is answered at all times. Calls received outside of normal office hours will be answered by the on-call provider. These calls may be subject to a fee.
- We offer a walk-in clinic with the following hours: 7am-4:45pm M-Thursday, and 7am-11:45am on Fridays. Antibiotics and similar medications will not be prescribed without evaluation in the office.
- Use of the online patient portal is the best and fastest method for patient/staff communication.
- Clients need to bring all medication bottles to every visit, including prescription, over-the-counter, and supplement bottles.
- You should request a medication refill via the pharmacy at least 7 days prior to your last dose. It may take up to 48 hours to fill your request. Controlled substance refill requests must be submitted no later than 48 hours prior to final dose. Controlled substances WILL NOT be filled by on-call providers.
- Medication refills will not be approved for clients who do not keep their follow-up appointments. Medication refills will not be called in after hours by on-call providers.
- Do not stop any medication prescribed by our office without contacting the office first.
- We prescribe/refill medications for maximum of 6 months at a time. Therefore, follow-up appointments for chronic issues must be scheduled every 6 months for proper management.
- Appointments not cancelled 24 hours prior to the scheduled appointment time may incur a NO-SHOW charge.
- Failure to keep your follow-up appointments as directed by your provider may result in dismissal from the practice.
- We offer an in-office laboratory and radiology department. Labs will not be ordered PRIOR to your appointment. If labs are needed, please expect to be sent to the lab after your office visit and plan accordingly. Afternoon lab appointments will not require fasting. If fasting labs are needed, you will give a future lab appointment.
- If you check your blood sugar or blood pressure at home, you must keep a log and bring it to every appointment. A log will be provided at your appointments.
- General Safety:
    - Do not take any mediation that is not prescribed for you. This can be dangerous due to certain medication interactions, disease processes, and allergies.
    - Please be considerate and avoid using cologne or perfumes during your office visit. Other individuals within your proximity may be unable to tolerate such fragrances for a variety of reasons.

Signed name of Client/Guarantor: ______________________________ Date: _______________

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ANNUAL EXAM VS. OFFICE VISIT
What's the difference?

Clarification of a complex billing situation that may occur during your visit to our facility.

- Annual Physical Exams, Wellness Exams, and Preventative Examinations usually occur yearly. These exams as particularly defined by insurers are "preventative examinations." The annual Wellness Exam includes age appropriate:
- Detailed questioning about health status, risk of health problems, disease processes;
- A complete physical examination of the individual;
- Preventative screenings which can require labs and referrals for procedures (colonoscopies, mammograms, dexa's, etc.)
- Health guidance and education including diet/exercise recommendations and potentially much more.

Because of the extensiveness of the Wellness Exam, extra time is minimal during the allotted office visit. Past, current, or new disease processes managed by the physician are done at a separate office visit because they fall OUTSIDE of the "preventative examination."

If the provider must address such individual medical problems during a preventative visit, an ADDITIONAL office visit charge will be added to the existing preventative charge for the visit.

Most insurers will cover our attention to these individual medical problems. However, some may shift an additional copay or deductible charge back to your for payment. Please be aware of this possibility if we need to address individual medical problems during a "preventative examination."

We believe in taking our time getting to know you and providing the best possible care to you and your family. To do this, we ask that you please contact us with health concerns prior to your annual Wellness Exam. We can then schedule a separate appointment to address these concerns if needed. Your cooperation ensures you receive the quality of care we want to provide in the time we have with you. Although we are not always able to address everything immediately, we do our best to address your concerns within the time scheduled for your appointment without sacrificing quality.

Signed name of Client/Guarantor: ______________________________ Date: _______________