Patient Information

Date: _____ Birthdate:_____Age_____
Pt Name: _____ Last 4 of Social Sec.#: _____
Address: _____ Sex: Male Female
City:_____State:____Zip:_____ Marital Status: S M D W (Circle One)
Phone:_____Driver's License #: _____
Work Phone: _____
Spouse: _____ Phone:_____
Emergency Contact:_____ Phone:_____
Relationship to Emergency contact:_____
Email: _____ (To be used only for non-medical notifications, appointment reminders, etc.)

Pt Employer:_____ Occupation:_____
Address: _____ City:_____State:____Zip:_____
Employer Phone: _____

Who will be responsible for payment of any charges today? (Including co-pays and deductibles)_____

Method of payment: Cash Check Credit Debit (Circle One)

Insurance Information

Primary Insurance Co: _____Ins Phone#_____
Address: _____ City:_____State:____Zip:_____
Name of Insured: _____ DOB:_____Relationship:_____
ID No: _____ Group No:_____
Co-Pay: _____

Secondary Insurance Co.: _____Ins Phone#_____
Address: _____ City:_____State:____Zip:_____
Name of Insured: _____ DOB:_____Relationship:_____
ID No: _____ Group No:_____

Referring Physician:_____ Phone #_____

NAME:_____

Reason for visit:

_____

_____.

MEDICAL HISTORY:

(Please circle all that apply to you)

Asthma	Yes	No
Bleeding Disorder	Yes	No
Blood Transfusions	Yes	No
Cancer	Yes	No

If yes, please explain

_____

Chest pain	Yes	No
Coronary artery disease	Yes	No
Diabetes	Yes	No
Dialysis	Yes	No
Heart Attack	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
HIV	Yes	No
Intestinal Problems	Yes	No

If yes, please explain

Kidney Problems	Yes	No
Liver Problems	Yes	No
Lung Problems	Yes	No
Thyroid Problems	Yes	No
Ulcers	Yes	No
Vascular Disease	Yes	No

Other: _____

_____

_____

Do you or have you ever smoked?	Yes	No

If so, how much? _____

When did you quit? _____

Do you drink alcohol?	Yes	No

If so, how much?_____

Family History of Cancer?	Yes	No

If yes, please explain

_____.

Date of last EKG _____

Date of last chest X-Ray _____

Date of last bloodwork _____

MEDICATIONS:

Please list your current Medications:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

ALLERGIES:_____

_____

SURGICAL HISTORY:

Please list any prior surgeries:

1._____

2._____

3._____

4._____

5._____

Other Physicians that are currently treating you:

_____

_____

_____

Assignment of Benefits, Consent to Treat and Payment Policy

Financial Policy

- Payment in full is expected at the time of service. For scheduled surgical procedures, payment is must be made prior to the procedure date.
- If our office has a contract with your insurance company, we will file a claim on your behalf. However, you will be required to pay and co-pay, deductible, and/or co-insurance for which you are responsible.
- Your insurance is a contract between you and your carrier, and we will make a reasonable effort to verify your benefits. However, ***it is your responsibility to know and understand your benefits***. Unfortunately, it is not uncommon for insurance companies to give us incomplete or incorrect information that can affect payment.
- If your insurance company does not pay as expected, for any reason, or if they choose to delay payment, you will be responsible for payment within 45 days of the service.
- We do not file claims for foreign insurance companies or "travelers" or "temporary" insurance.
- There is a $25 fee for returned checks.
- You are responsible for obtaining any necessary referrals prior to your appointment. If you do not have the needed referral, you will be responsible for the charges prior to being seen. If you reschedule your appointment due to lack of a referral, you will be charged a $25 fee the same as a "no-show."
- If you cancel or "no-show" for your office appointment with less than 24 hours advance notice, you will be required to pay a $25 fee before another appointment will be scheduled.
- If you cancel, reschedule or "no-show" for a scheduled surgical procedure with less than 48 hours advance notice, you will be be required to pay a $50 fee prior to rescheduling. (Please understand that we reserve a significant block of the Operating Room schedule and spend a considerable amount of time in doing the required paperwork for your procedure.)
- If you receive a statement for an outstanding balance, payment in full is due within 10 days. If you believe there is a mistake or if you dispute a charge or amount, you must notify our office within 10 days.
- There is a $7.00 Statement Fee that will be applied to each statement after the first statement.
- **After two statements are sent, or if you fail to respond to phone calls and/or letters, your account may be turned over to a collection agency. You hereby agree to reimburse Dr. Parker the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.**
- I authorize the use of any credit card, debit card or bank account information provided for any payment to be used to satisfy any outstanding balance on accounts for which I am responsible. Although we are hereby not obligated to do so, we will make reasonable efforts to contact you prior to processing such charges.

Consent to Treatment

I hereby give permission to the physician and whomever he may designate as his assistant, to administer such evaluation and treatment as is necessary based on the findings during examination or treatment.

Notice to Patients of Financial Interest

You are hereby informed that Dr. Parker holds a financial interest in the Las Colinas Surgery Center and Texas Health Presbyterian Hospital Flower Mound. You have the option, at your discretion, to use an alternate health care facility.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plan to Ralph. R. Parker, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all the charges whether or not paid by my insurance. If you have insurance, we will file your claim as a courtesy to you. However, if Dr. Parker has not received payment after reasonable effort, I hereby authorize said assignee to release all information necessary to secure payment and, in addition, authorize the use of any credit or debit card information provided for any payment to be used to satisfy any outstanding balance on accounts for which I am responsible.

By my signature I hereby understand and agree to comply with the above Financial Policy, Consent to Treatment Policy and Assignment of Benefits.

Signature_____ **Date**_____

Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by Ralph R. Parker, M.D., our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practice***s carefully. It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, or by contacting our manager at 972-874-3400.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment / service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent to the medical practice use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient or Surrogate Decision Maker :

_____ **Date:**_____

Relationship to Patient/ Legal authority *(if applicable)*: _____

***For Practice use only*:**

Failure to obtain consent
Indirect Treatment Relationship
Substantial Communication Barrier
Other Description:

Check the appropriate reason:
Emergency treatment
Refusal to Sign

_____ _____

Practice Signature **Date**