**Ralls Family Medicine**

**Patient Information Sheet**

Name:

Address:

City: State: Zip:

Primary Phone: Alternate Phone:

Social Security #: Email Address:

Date of Birth: Age: Marital Status:

**Spouse or Parent Information**

Name: Relationship:

Primary Phone: Alternate Phone:

**Emergency Contact Information**

Name: Relationship:

Primary Phone: Alternate Phone:

Name: Relationship:

Primary Phone: Alternate Phone:

**Insurance Information**

Primary Insurance Company:

Insured’s Name: Insured’s D.O.B.

Secondary Insurance Company:

Insured’s Name: Insured’s D.O.B.

**General Consent for Care and Treatment**

This consent provides Ralls Family Medicine/John Hodges FNP-C to perform reasonable and necessary medical examinations, testing and treatment. By signing this agreement, you are stating that 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. You have the right to discuss the treatment plan with your provider as well as any test results or other information relevant to your services or treatment. If you have any concerns regarding your health care or treatment recommended by your provider, we encourage that you speak up and ask questions.

You have the right as a patient to be informed about your health condition and any recommended treatment options so that you can make an informed decision as to treatment options to consider. At this point in your care, no specific treatment plan has been recommended. This consent form simply is meant to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to treatment.

 **Signature of patient or personal representative Date**

**Printed name of patient or personal representative Relationship to patient**

**Signature of witness Date**

**Authorization for Payment and/or Release of Information to**

**Private or Supplemental Group Insurance**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Patient Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Address

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:**  I hereby authorize payment directed to the provider for services provided, not to exceed the reasonable and customary charge for those services (This allows us to collect payment or bill insurance).

X

Signature (insured person, parent or legal guardian) Date

**AUTHORIZATION TO RELEASE INFORMATION :** I hereby authorize the provider to release protected health information to another organization (such as another health care provider) when the appropriate documentation has been submitted for request.

X

Signature (insured person, parent or legal guardian) Date

**MEDICARE:** I request the payment of authorized Medicare benefits be made either to me or on my behalf to Ralls Family Medicine/John Hodges FNP-C for any services furnished me by that professional organization. I authorize the legal release of appropriate health care information to Medicare and its agents in order to determine reimbursement for services (this allows us to collect payment or bill medicare).

X

Signature (only if you have Medicare)**Ralls Family Medicine**

**Financial Policy**

We want to thank you for choosing Ralls Family Medicine for your medical care. This financial policy has been developed to make sure you understand our billing practices to avoid any confusion.

For your convenience, we accept payment by cash, check, credit card and debit card.

We participate with most insurance plans including medicare. If you do not have insurance, payment in full is expected at the end of each visit.

All copays must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments from patients can be considered insurance fraud.

No-show: If you are unable to make and appointment that has been scheduled, please try to notify the clinic at least 24 hours in advance to avoid a possible cancellation fee.

Form Completion: All forms requiring medical review and provider signature such as FMLA, disability, etc. are subject to a $25.00 cash fee. These charges are not covered by insurance and must be paid prior to completion of the form.

Nonpayment: If your account is over 60 days past due, your account will be turned over to a collections agency. We are willing to negotiate payment arrangements for anyone who might be having trouble paying for services.

I have read and understand the payment policy and agree to abide by its guidelines.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of responsible party Date**

**Notice of Privacy Practices for Protected Health Information**

**Ralls Family Medicine HIPAA Notice**

**NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION [45 CFR 164.520]**

**Background -** The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

**Our Obligation -** We are required by law to 1. Maintain the privacy of your protected health information 2. Give you this notice of our legal duties and privacy practices regarding your health information 3. Follow the terms of our notice that is currently in effect.

**Treatment -** We may need to use and disclose health information that identifies you, but only with written permission in order to provide a continuance of medical care.

**Payment -** We may need to use and disclose health information that identifies you, but only with written permission, in order to provide information to your insurance company so that they may pay for your care.

I**ndividuals involved with your care -** We may use and disclose health information with a person who has consent, that may be involved in your medical care or may be paying for your medical care. We may also notify your family about your location of general medical condition only in an emergency or disaster relief effort.

**As required by law -** We may need to disclose your health information when required to do so by federal, state, or local law.

**Business Associates -** We may need to share health information with insurance companies or billing services in order to make sure claims are reimbursed appropriately.

**Public Health Risks -** Sometimes your health information has to be shared by law to entities such as the health department in order to help prevent the spreading of disease, injury, disability or death.

**Lawsuits and disputes -** We may need to release certain health information as required by law for dispute or settlement of lawsuit or in response to a subpoena.

**Your written authorization is required for other uses and disclosures -** The following uses and disclosures of your health information will be made only with written consent of patient 1. Uses and disclosures of protected health information for marketing purposes 2. Disclosures that constitute a sale of your protected health information.

**YOUR RIGHTS**

You have the following rights regarding health information we have about you:

**Right to inspect and copy -** You have the right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes all records, notes, billing sheets, labs, etc.

**Right to a copy of your medical records -** You have a right to a copy of your medical records. We will make every effort to make sure you have access to your medical records when needed.

**Breach of Data -** you have the right to receive notice of breach of data in regards to your protected health information.

**Right to amend -** If you feel that your health information is incorrect, you have the right to ask for an amendment of the information.

**Right to Accounting of Disclosures -** You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment, and health care operations or for which you provided written authorization.

**Out of pocket payments -** If you are paying out of pocket for services, you have the right to ask that your health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**Rights to paper copy of this notice -** You have the right to request paper copies of this notice if you do not have a paper copy.

**Complaints:** if you believe that your privacy right has been violate, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

To file a complaint with our office, contact us at RallsFamilyMedicine.Com and voice your concern.

Contact Person -

John C. Hodges, FNP-C/Owner Ralls Family Medicine PLLC.

711 Main St Ralls, Tx 79357-3330

(806) 253-7111

**Ralls Family Medicine PLLC**

**John Hodges FNP-C**

**Acknowledgement of Receipt of Notice of Privacy Policy**

I, , acknowledge that I have received a copy of Ralls Family Medicine’s privacy policy(HIPAA).

X

Patient Signature Date

X

Patient legal representative Date

X

Print name of legal representative Relationship to patient

**For Ralls Family Medicine Use Only**

Ralls Family Medicine/John Hodges FNP-C made the following good faith efforts to obtained the above-referenced individual’s written acknowledgment of receipt of the Notice of Privacy Practices.

X

Ralls Family Medicine Representative Date

**Ralls Family Medicine**

**Consent for Disclosure**

Consent for disclosure of protected health information

 (initial) I consent to Ralls Family Medicine employees identifying themselves and leaving voicemail/messages on answering machines for the purposes of appointment confirmation, follow up, or other clinic related issues.

 (initial) I consent to Ralls Family Medicine employees identifying and leaving a message with those who might answer my phone for the purposes of appointment confirmation, follow up, or other clinic related issues.

 (initial) I consent to Ralls Family Medicine employees disclosing my private health information such as test results and billing information with a designated family member or personal representative.

* **If yes, please designate the person(s) to whom such information may be disclosed:**

Name: Relationship:

Phone number

Name: Relationship:

Phone number:

Name: Relationship:

Phone number

Name: Relationship:

Phone number:

Name: Relationship:

Phone number

Name: Relationship:

Phone number:

**Patient Signature: Date:**

**Witness Signature: Date:**

**Ralls Family Medicine**

**John Hodges FNP-C**

Medication and History reconciliation

Patient Name:

Patient Date of Birth:

Major Surgical History:

| Surgery Date | Type of Surgery | Name of doctor or hospital |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Current Medications:

| Name of Medication | Dose and Frequency | Why do you take this medication? |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Current Pharmacy:**

**Allergies**

| **What are you allergic to?** | **What is the reaction** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |