PLANO FAMILY CLINIC

PATIENT NAME_____DOB_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____ALTERNATE PHONE_____

SSN_____EMPLOYER_____

SPOUSE/PARENT NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE_____ Referred by_____

EMAIL _____

INSURANCE INFORMATION

PRIMARY INSURANCE_____INSURED NAME_____DOB_____

ID#_____INSURED NAME_____

SECONDARY INSURANCE_____INSURED NAME_____

ID#_____GROUP#_____PHONE_____

EMERGENCY CONTACTS

NAME_____RELATIONSHIP_____PHONE_____

NAME_____RELATIONSHIP_____PHONE_____

I hereby authorize Plano Family Clinic, PLLC to release any and all information necessary for filing claims for services I received to the insurance companies listed above. I hereby authorize the insurance companies listed above to make payment of benefits directly to Plano Family Clinic, PLLC for the services rendered.

***Please complete every field if applicable. It is necessary in processing of an accurate claim to your insurance company.**

PLANO FAMILY CLINIC

In our efforts to comply with **Health Insurance Portability and Accountability Act (HIPAA)**, we need to be certain that we guard your privacy according to your wishes concerning your family, friends, and co-workers.

Please circle your response to the following

May we leave messages concerning your appointments, treatment and/or results on your voicemail at home?
Yes No N/A

May we discuss your appointments, treatments and/or results on your cellular voicemail?
Yes No N/A

May we leave messages concerning your appointments, treatments, and/or results on your voicemail at work?
Yes No N/A

May we discuss your appointments, treatments and/or results with your children over the age of 18?
Yes No N/A

May we discuss your appointments, treatments and/or results with your spouse?
Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments, treatments and/or results with your parents? Yes No N/A

May we leave messages concerning your appointment, treatments and/or results with your co-workers, a receptionist or individuals that regularly answer your calls? Yes No N/A

You must inform us in writing of any changes in your directives.

Patient Name:_____

Signature:_____ Date:_____

PLANO FAMILY CLINIC

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by requesting from our staff.

I, _____, have received/reviewed a copy of this offices' Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

PLANO FAMILY CLINIC

I normally get my prescriptions from:

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____

Street City State Zip

Patient Portal Consent: The patient portal is a secure website that allows you to view your medical information on the computer or Healow app on your cell phone. The Patient Portal also allows you to communicate with the Practice via secure messaging. Please note that all communication via the Patient Portal will be included in your permanent patient record.

I authorize Plano Family Clinic to use my email for the patient portal communication purposes only.

□ Yes □ No

I choose not to participate in patient portal at this time because:

□ I do not have an email address
□ I do not wish to share my e-mail address
□ English is not my preferred language
□ Other

Email: _____

Patient Name (printed) _____ Patient Signature: _____

Date: _____

PLANO FAMILY CLINIC

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. ***Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.***

1. On arrival, please sign in at the front desk and have your current insurance card ready at every visit. IF THE INSURANCE INFORMATION PROVIDED IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments, deductibles, and coinsurances are due at time of service and are provided as an estimate from your insurance company. You are responsible for paying the fully determined amount by your insurance company once they have paid your claim, regardless of our estimation. **Not all services provided may be covered by your plan**. Any services not covered by your plan will be your responsibility. **It is your responsibility to know your insurance plan benefits**. If you have no insurance, payment for an office visit and any other testing is to be paid at the time of the visit.
3. We do submit to secondary insurance plans. If you have secondary insurance, please provide a copy of your secondary insurance card. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
4. If our physician does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
5. Patient balances are billed immediately on receipt payment is due *within* 10 business days of your receipt of your bill. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our financial office within 10 days after receipt of the initial statement. Please call Synergy Billing at 214-715-6526.
6. If previous arrangements have not been made with our finance office for payment of past due balances, your account will be sent to a collection agency. Any balance over 90 days will be forwarded to a collection agency.
7. A **$40** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date

PLANO FAMILY CLINIC

Clinic Policies and Procedures

Appointment Scheduling: If you are unable to make it to your scheduled appointment, we ask that you notify us 24 hours in advance whenever possible. Repetitive no-shows and cancellations with less than 24 hours' notice may be subject to a $25 no-show fee for appointments Multiple no-shows may result in discharge from the practice.

Payments and Balances: Payment is expected at the time of service and will be collected at check in. The amount due, if any, is determined by the contract you have with your insurance company and is based on the complexity of your visit in conjunction with your coverage. If a balance is due for your visit, you will be asked to pay in full at check out.

Prescriptions and refills: If you are prescribed a controlled substance that you take regularly, you will be required to return to the office on a regular basis for renewed prescriptions and to sign a copy of our Controlled Substances Agreement.

Portal and Electronic Communications: Any electronic communication to the office should be done through your patient portal to be secure and to protect your privacy and medical information.

Medical Records Request: We charge **$25** for the first 20 pages and $0.50 cents per page thereafter to copy or transfer medical records. If an affidavit is needed, there is an additional $15 charge. If you request forms to be completed, there is a **$25** charge per form unless there is an associated office visit. Payment is due when the forms are dropped off. We have a 2 week turnaround time for forms. If a form is needed sooner than 3 days, there is an additional **$10** *rush* fee.

Insurance/ Physician Referrals: Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Your primary care physician must approve referrals before being issued.

Contacting the Office: The office is available during business hours by phone, fax, and through your patient portal. We will respond to most voice messages the same day by close of business, and calls received after 3pm may not be returned until the next business day. While we make every effort to answer all incoming calls, you may have to leave a message if a staff member is not able to answer your call. Please do not call the office repeatedly, as it delays our ability to assist you in a timely manner.

Patient Name:_____

Signature:_____ Date:_____

PLANO FAMILY CLINIC

Patient No-Show and Cancellation Policy

We strive to provide excellent and prompt medical care to all of our patients. In order to be consistent with this, we have adopted a Patient No-Show and Cancellation Policy for our clinic. When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient.

Our policy is as follows: You may cancel your appointment up to two (2) business days before your scheduled appointment with no consequences. We will be happy to reschedule the appointment for you and leave the open time for another patient. If you miss your appointment or cancel less than 24 hours before your appointment, Plano Family Clinic reserves the right to bill you $25.00 for each no-show or late cancellation during a weekday and $45.00 for Saturday appointments and is not billable to insurance. This fee is t

Additionally, if a patient is more than 10 minutes late to his/her appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee will apply.

We do realize that, on occasion, emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

If you have any questions regarding this policy, please direct them to the practice manager. We thank you for working with us to ensure that we are able to provide the best service possible to all of our patients.

I have read and understand the Patient No-Show and Cancellation Policy and I agree to the terms.

Printed Patient Name _____ DOB: _____

Patient Signature _____Date _____