SupraCare

NEW PATIENT INFORMATION

Last _____ **First** _____ **MI** _____

DOB _____ **SS#** _____ **Male or Female**

Address _____ **City** _____ **ST** ____ **Zip** _____

Hm Phone _____ **Cell** _____

Employer Name _____ **Phone#** _____

Emergency Contact Name _____ **Phone#** _____

Marital Status: Single ____ **Married** ____ **Divorced** ____ **Separated** ____ **Widowed** ____

Preferred Pharmacy _____ **Email** _____

INSURANCE INFORMATION

PRIMARY

Plan Name _____ **ID#** _____ **Group** _____

Policy Holder's Name _____ **DOB** _____ **SS#** _____

SECONDARY

Plan Name _____ **ID#** _____ **Group** _____

Policy Holder's Name _____ **DOB** _____ **SS#** _____

The undersigned patient (or patient's representative) consents to allow *SupraCare Family Health* to provide medical care, testing, and treatment according to the judgement and diagnosis of the provider in attendance that are deemed necessary and advisable. This care may include additional testing such as laboratory tests, EKGs, X-rays, and other necessary test to ensure proper diagnosis and accurate treatment. Treatment may include administering medications (injections, IVs), surgical procedures (lancing abscesses, sutures, removal of skin anomalies, etc), as well as papsmears, toenail removal, ear irrigations, and other invasive procedures. I understand that if, at any point, I do not wish to have such testing or treatment performed I am responsible for notifying the provider or nursing staff that I want to decline testing and/or treatment. I also understand that if I fail to notify the provider or nursing staff, I cannot hold the provider or clinic liable for any incurred charges from such testing or treatment. I understand that it is my responsibility to contact my insurance carrier prior to testing and/or treatment to determine coverage for such services.

_____ _____

Patient or GuardianSignature **Date**

SupraCare

Consent to Communicate Protected Health Information (PHI)

Patient Name_____ **DOB**_____ **SS#**_____

Due to the Health Insurance Portability and Accountability Act (HIPPA) of 1996, medical records and account information are, by law, very protected. This clinic will ONLY communicate or disclose your PHI to the person or persons listed below and ONLY as described below.

I grant permission to SupraCare Family Health to communicate information about my Medical Treatment (PHI) and/or my Medical Account Information to the person/persons I have listed below.
(Mark ALL that apply)

Name	Relation to Patient		
_____	_____	☐ Treatment	☐ Account
_____	_____	☐ Treatment	☐ Account
_____	_____	☐ Treatment	☐ Account
_____	_____	☐ Treatment	☐ Account
_____	_____	☐ Treatment	☐ Account

I understand that myself or my legal representative may revoke this authorization at any time by providing written notice to SupraCare FamilyHealth.

I understand that information released to authorized individuals listed above my be disclosed to others via these recipients which may cause this information to no longer be protected by Federal and Texas privacy laws.

I understand that this consent DOES NOT apply to release of information regarding my spouse, children, or any other family member over the age of 18. I understand that they must obtain their own individual consent for release and disclosure of their Protected Health Information (PHI).

I understand that this information may include information relating to Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); treatment for drug and/or alcohol abuse; mental/behavioral health or psychiatric treatments.

☐ ***I have chosen to create a password and I understand it is my responsibility to relay this password to the above listed authorized person/persons.***

Passoword: _____

☐ ***I have read and understand the information on this form.***

_____ _____

Signature ***Date***

310 E. Hoskins, New Boston, TX 75570 P(903)628-7877 F(903)628-7876

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide a 24 hour notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours, we may be unable to offer that slot to other people.

Office appointments which are cancelled with less than a 24 hour notification may be subject to a $25.00 cancellation fee. Procedure cancellations also require a 24 hour advance notice, and without proper notification you may be subject to a $50.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as a NO SHOW. Patients who NO SHOW three (3) times in a 12 month period, will be dismissed from the practice and will be denied any future appointments. Patients may also be subject to a $50.00 office appointment and procedure NO SHOW fee.

The Cancellation and NO SHOW fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel with less than 24 hour notice. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician-patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (903)628-7877.

Please sign that you have read and understand this Cancellation and NO SHOW Policy.

_____ Date of birth _____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative Date

FINANCIAL POLICY

We are committed to providing you the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our FINANCIAL POLICY which we require that you read and sign prior to any treatment. You are required to provide us with your most current billing information and notify us immediately of any changes.

We accept cash, checks, credit cards, and money orders as form of payment. There is a $30 charge for every returned check.

MEDICARE/MEDICAID

As a participating provider for these programs, we accept assignment of benefits and will file all insurance claims for you. You may be responsible for full payment of any deductible and/ or coinsurance at the time services are rendered.

PPO/HMO AND OTHER MANAGED CARE

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we are happy to file your insurance claims. However, you are responsible for paying all copayment, deductibles, coinsurance, and non-covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of the insurance companies we participate with. Even with assignment of benefits, you are still ultimately responsible for all charges. If your carrier has not paid on your account within 30 days, it is your responsibility to contact the payer regarding your claim and notify our billing department of the status.

PERSONAL INJURY (accidents)

We do NOT get involved with third-party claims such as motor vehicle accidents or Workman's Compensation.

SELF PAY

Payment of services is due at the time services are rendered. Balances MUST be PAID IN FULL before your next appointment. Payment plans may be arranged but must have approval prior to appointment time. Balances on payment plans MUST be PAID IN FULL in 3 months or less.

DELINQUENT ACCOUNTS

Accounts that are not paid in full or satisfactory arrangements have not been made within 3 months (90 days) of the date services were rendered will be considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau, and/or to our attorney for further action. All collection fees are charged to the patient.

Please let us know if you have any questions. Sign and date below stating that you have read and understand our Financial Policy.

_____ _____

Signature **Date**

SupraCare

Patient Name_____ **DOB**_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The notice of Privacy Practices for SupraCare Family Health has been made available for me to review. I understand that I may request a copy for myself of this notice or obtain a copy from their website at www.supracareclinic.com at any time. I also understand that I will receive notice of any changes made to the Privacy Practices for SupraCare Family Health when any changes are made or access the revised copy on the website provided above.

_____ _____

Signature **Date**

COMMUNICATIONS CONSENT

I give permission for SupraCare Family Health to contact me in the following manner: (please mark all that apply and provide phone numbers for those choices)

Verbal Communication:

____ **Home Phone #:** _____ **Leave message w/information: Y N**

____ **Cell Phone #:** _____ **Leave message w/information: Y N**

____ **Work Phone #:** _____ **Leave message w/information: Y N**

Our office uses an automated calling system for appointment reminders, account notifications, and notifications of receipt of test results. If you DO NOT wish to receive communications via automated system, you must notify the receptionist so that this service can be turned off.

_____ _____

Signature **Date**

SupraCare

PATIENT HISTORY SHEET

Name: _____ DOB: _____ Age: _____

Allergies: _____

_____ ☐ NKDA (No known drug allergies)

PATIENT PAST MEDICAL HISTORY

Do you have or have you ever been diagnosed with:

_____ADD/ADHD	_____Chicken Pox	_____GERD
_____Allergies	_____Chronic Pain	_____Gout
_____Anemia	_____Congenital Anomalies	_____H-Pylori
_____Angina	_____Constipation	_____Head injury (concussion)
_____Anxiety disorder	_____Coronary Artery Disease	_____Headaches
_____Arthritis	_____DVT/blood clot	_____Heart problems/disease
_____Asthma	_____Depression	_____Heart Attack
_____Autism	_____Developmental/Behavior	_____Hepatitis Type_____
_____Auto Immune	_____Diabetes Type 1	_____High Cholesterol
_____BPH	_____Diabetes Type 2	_____Hypertension
_____Bedwetting	_____Diabetes Type 2-insulin	_____Hyperthyroidism
_____Bipolar	_____Diverticulitis	_____Hypothyroidism
_____Bladder/Kidney problems	_____Diverticulosis	_____Liver disease
_____Blood disease	_____Erectile Dysfunction (ED)	_____Lupus
_____COPD	_____Ear/Hearing problems	_____Mental Illness
_____Cancer	_____Fibromyalgia	_____Muscle/Joint/Bone problems

**Cont. past medical history

OTHER:

_____Osteoporosis

_____Stroke

_____Pulmonary Embolism

_____Tuberculosis

_____Pancreatitis

_____Vision/Eye problems

_____Seizures/Epilepsy

_____Migraines

_____Sickle Cell

_____Emphysema

_____Skin Problems

_____Vascular disease

MEDICATIONS
Please list current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

OTHER PROVIDERS
Please list other providers you may see:

Name of Provider — Type of Provider

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HEALTH HABITS
Mark all that apply:

_____Caffeine—small moderate heavy _____Tobacco—packs per day_____ Dip-cans per day_____

If you are not a current smoker, have you ever smoked? Y or N Date you quit_____

_____Alcohol—Frequency:_____ _____Street Drugs—Type_____ Frequency:_____

I certify that the information given above is correct and true to the best of my knowledge. I will not hold SupraCare Family Health or any of their staff at fault for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date