PATIENT'S REGISTRATION

5750 Bunker Hill Road – Garland, Texas 75048 – Tel: 972 675-5300 – Fax: 972 675

PATIENT'S INFORMATION

☐ MR. ☐ MS. ☐ MRS. ☐ DR. LAST NAME FIRST MIDDLE

☐ MALE ☐ FEMALE | ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

SOCIAL SECURITY #: DATE OF BIRTH: SPOUSE NAME:

HOME ADDRESS: APT#: CITY: STATE:ZIP:

HOME#: CELL#: WORK#: EMAIL:

EMPLOYER: CITY:STATE: ZIP:

EMERGENCY CONTACT PERSON(S): CONTACT#:

PREFERRED COMMUNICATION: ☐ HOME # ☐ CELL# ☐ WORK# ☐ EMAIL ☐ MAIL ☐ DECLINE ☐ OTHER

GUARANTOR INFORMATION (Person Responsible for Payment of Bill)

NAME: RELATIONSHIP: DOB: SS#:

HOME ADDRESS: APT#: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE:ZIP:

OCCUPATION: CELL#: WORK#:EMAIL:

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED NAME:		
INSURANCE CO.:		
POLICY #:		
GROUP NAME#:		

***IF THE PERSON INSURED IS DIFFERENT FROM THE GUARANTOR, PLEASEPROVIDE THE INFORMATION BELOW SO WE CAN ASSIST YOU IN FILING YOUR MEDICAL CLAIM.**

NAME: RELATIONSHIP: DOB: SS#:

HOME ADDRESS: APT#: CITY: STATE: ZIP:

EMPLOYER: CITY: STATE: ZIP:

OCCUPATION: CELL#: WORK#:EMAIL:

☐ I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I RELEASE YOU FROM ALL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED.

☐ I DO NOT AUTHORIZEYOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. IN DOING SO I AM RESPONSIBLE FOR MY MEDICAL BILLS.

Signature of Patient/Legally Authorized Representative   Date

PATIENT HEALTH HISTORY

PATIENT NAME: ______________________________ DATE OF BIRTH:___________ AGE:_______ ☐ MALE ☐ FEMALE

HOME PHONE: __________________________________ WORK PHONE: ____________________________

RETAIL PHARMACY:____ PHONE:______________________________________

MAIL ORDER PHARMACY: ____ PHONE:______________________________________

REASONS FOR THIS VISIT:____

PLEASE LIST THE NAMES OF ALL PHYSICIANS YOU CURRENTLY SEE:

____ ____

____ ____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING DOSE AND HOW OFTEN YOU TAKE IT)

____ ____

____ ____

____ ____

____ ____

____ ____

PLEASE LIST ALL OVER THE COUNTER MEDICATIONS (EXAMPLES: Tylenol, Advil), HERBAL SUPPLEMENTS AND VITAMINS YOU CURRENTLY TAKE.

____ ____

____ ____

ALLERGIES: ____

PREVIOUS MEDICAL HISTORY:

Do you suffer from any of the following medical conditions?

Condition	Yes	No
HIGH BLOOD PRESSURE	☐ Yes	☐ No
HEART DISEASE	☐ Yes	☐ No
STROKE	☐ Yes	☐ No
DIABETES	☐ Yes	☐ No
ASTHMA	☐ Yes	☐ No
MALIGNANCY/CANCER	☐ Yes	☐ No
SEIZURES	☐ Yes	☐ No

CHECK IF ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

Condition	Yes	No	**Relationship to you**
HIGH BLOOD PRESSURE	☐ Yes	☐ No	____________
HEART DISEASE	☐ Yes	☐ No	____________
STROKE	☐ Yes	☐ No	____________
DIABETES	☐ Yes	☐ No	____________
ASTHMA	☐ Yes	☐ No	____________
MALIGNANCY/CANCER	☐ Yes	☐ No	____________
SEIZURES	☐ Yes	☐ No	____________

DO YOU SMOKE/HOW OFTEN? ______________________

DO YOU USE ALCOHOL/HOW OFTEN? ____________________

FOR FEMALE PATIENT ONLY: DATE OF YOUR LAST MENSTRUAL CYCLE? ____________________

LIST ANY SURGERIES: ____

LIST OTHER ILLNESSES: ____

____

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my doctor, his consultants, associates and his assistants, or his designee. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me.

I authorize Dr. King and his assistants/designee to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse. I have the right to add anyone or any organization that I do not wish to have my medical information by requesting in writing at any time.

I understand there are times when the law allows Dr. King and his assistants/designee to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Dr. King and his assistants/designee may release information to doctors, nurses and other who provide me with health care or are prospective health care providers; to government agencies as authorized by law to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

I also understand and acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, Dr. King and his assistants/designee may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Dr. King. I understand that the results of tests taken under these circumstances are confidential and do not become a part of my medical record.

I acknowledge that it may be difficult for the physician(s), his/her assistants, or his/her designee to personally communicate with the patient regarding laboratory/diagnostic test results, etc.It is the policy of Dr. King's Office to leave this information on the patient's telephone answering machine.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Dr. King has made no guarantees or warranties to me as to the result of treatments or examination.

It is the policy of Dr. King's Office not to release confidential medical information to patient's family members. We cannot discuss your medical condition, or release diagnostic test results to anyone without your consent. I hereby give consent that information regarding my medical condition, including laboratory and diagnostic test results can be given to:

a. ____ Relationship _______________________

b. ____ Relationship _______________________

c. ____ Relationship _______________________

____ ________________
Signature of Patient/Legally Authorized Representative Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is being provided to you in accordance with the requirements of the Standards for Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (HIPAA) and by the amendments to the HIPAA Privacy Rules made by the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act).

I acknowledge that Ihave been provided with King Family Medical (KFM) Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this content. I understand that KFM reserves the right to change its Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I have provided.

By signing this form, I consent to KFM use and disclosure of my health information for treatment, payment, and health care operations.

PATIENT INFORMED CONSENT FOR ELECTRONIC MEDICAL SERVICES

KFM has implemented an electronic health record in part to meet the U.S. Department Health and Human Services initiative to improve health information technology, toward the goal of improving quality of health care. Our electronic health record integrates your clinical record with appointments, registration, and billing and makes this information available to the clinicians who are involved in your health care.

In connection with its electronic communication systems, KFM has also implemented and has in place privacy and security policies and procedures to minimize risk of inadvertent or unauthorized disclosure, corruption and/or loss or distortion of data, but as with all record keeping systems, whether paper or digital, some risks remain of loss, inadvertent disclosure or errors in the recorded data.

I have read and understand the information provided regarding Electronic Medical Services, have discussed it with my physician, his/her assistants, or his/her designee, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of Electronic Medical Services in the course of my diagnosis and treatment and consent to the electronic communication of my personal health care information to other entities for treatment, payment or health care operations, including electronic transfer of medical data to other medical practitioners participating in my medical care.

INFORMED CONSENT FOR PRESCRIPTIONS

KFM continues its position as the network exchange for the flow of vital patient information to physicians and other health care providers. It is essential to improve patient safety and the continuity of care with electronic connectivity between payers, physicians and pharmacists. KFM electronic health record (EHR) provides secure access for patients with commercial prescription coverage in the United States.

Prescription eligibility, benefit, formulary and medication history information is provided for consenting patients to authorized physicians at the point of care. Electronic prescriptions are delivered in real-time to pharmacists in the retail and mail order settings.

I consent to electronic prescriptions and acknowledge that KFM will use electronic connectivity between payers, physicians and pharmacists.

____ ________________
Signature of Patient/Legally Authorized Representative Date

INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

Welcome to King Family Medical**.**Webelieve that you deserve the best care. That's why we always provide you with the best medical care possible to treat your personal situation. Each year we provide outstanding medical care to hundreds of patients. Some have medical benefits but some don't. If you have medical benefits, congratulations! You are very fortunate. Here are some important things you should know:

INITIAL:

_____ ▪ Your medical benefits are based upon a contract made between you or your employer and an insurance company. If you have any questions regarding your medical benefits please contact your employer or insurance company directly. Most medical benefit plans will never pay 100% of your medical care. It is only meant to assist you.

_____ ▪We will bill your insurance as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company.** Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Any delinquency on your account will result in a $25 monthly late fee added to the account. In the event that we incur any expense in the collection of your account, expenses for collections agencies or court costs will be applied to your account.

_____ ▪ We currently accept all private pay, and most of the major commercial health insurance plans. This means that we work with literally hundreds of insurance companies. It is your responsibility to know if Dr. King is a contracted in-network provider recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quoteat the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.**If you would like to know your insurance benefit, we will be happy to file a "pre-authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. This does delay treatment but will give you the best estimate of what your out-of- pocket figures will be.

_____ ▪ It is**your responsibility** to know if your insurance has any deductibles, co-payments, agelimits, exclusions, waiting periods, clauses or any other type of benefit limitation for the services received. Many times these exclusions are provided to employees only & are not made available to our staff when confirming benefits. They are your responsibility to know and we can only estimate based on what your insurance discloses to us.

_____ ▪ We do require payment in full for your estimated portion at the time of service. We accept all major credit cards, cash and checks. If your check payment has a non-sufficient fund and is returned to us there will be a $25 fee. Any discount you may had at the time of service will be revolted, and your future payment must be in cash, credit or debit card.

_____ ▪ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we do require **at least 24 hours'** notice to avoid a $25 cancellation feefor office visit and a $35 cancellation feefor Physical/Wellness visit. (Emergencies are an exception).

______________________________________ ______________
Signature of Patient/Legally Authorized Representative Date

OFFICE POLICIES

Here are a few of our policies that we would like for you to be aware of:

Check In Process:

1. Insurance card and a valid ID are required during check in process for every visit.
2. A Patient/Parent/Guardian must notify the office of changes in address, telephone number or insurance.
3. You are required to pay your past due balance or balances.
4. You will be responsible for payment for charges of services rendered if we are unable to verify benefits.
5. We accept cash, checks, Visa, MasterCard, American Express, and Discover. (Payment is due at time of service)
6. Insurance companies require a collection of your co-pay or contracted percentage of services at **every** visit. If you have a deductible that has not been met, you will be required to pay for the visit at the contractual rate. If your insurance does not pay for a service, the charges will be the responsibility of the Patient/Parent/Guardian. We recommend that you always question your insurance company regarding your benefits and do not assume that everything done in our office is covered by your insurance carrier.

Appointments:

1. You must arrive 10-15 minutes prior to your appointment.
2. Rescheduling may be necessary if you are late for your appointment. We will try to work you in if time allows.
3. You are scheduled to be seen for only 15 minutes for an office visit and 20 to 25 minutes for a Physical/Wellness exam unless it is determined by Dr. King to extend your visit if additional time of care needed.
4. If you are being worked in to the schedule as a walk in, you are only allowed one medical complaint. You will **HAVE**to schedule an additional appointment for any additional medical concerns. Sick office visits are not considered routine follow up care, which require more time.
5. Wellness/Physical examinations cannot be scheduled on the day that you call. We reserve only a certain number of well examinations per day. In addition, well examinations cannot be conducted on an ill child. If your child is sick, we will need to reschedule the appointment.
6. If you are scheduled for a physical/wellness exam and you have other medical issues aside from your physical/wellness exam you will have copay for other issues due to separate insurance filling. If you disagree with our policies, then you will have to reschedule for another office visit.
7. Appointment cancelled with less than 24hrs notice will be billed with the following fees: $25.00 fee for a cancelled office visit and $35 fee for a cancelled physical/wellness appointment.

Financial Responsibilities:

1. ALL DUE BALANCES MUST BE PAID PRIOR TO BEING SEEN, unless you have made a financial arrangement with our office. (with the exception of emergency visits)
2. NO EXCEPTION for the following: Deductibles and Copay must be collected at the time of service.
3. Private Pay Patients will pay an estimated fee upfront. No Exception.
4. There is a $25.00 fee for returned checks.
5. Our office can no longer be involved in payment disputes between parents. The person who brings the child to the office will be expected to pay at the time of service.

Medication Refills:

1. Patients on medication for ADD/ADHD will be seen for medication check-ups every 3 months. Refills for ADD/ADHD medications will be provided only if these appointments are kept. Patients/Parents/Guardians may call the nurse to request a refill for ADD/ADHD medications. These prescriptions will be available for pick-up 48hrs after the request has been made during our regular business hours. ADD/ADHD medications must be picked up and filled within 7 days of the date the prescription was written. In the event it is not picked up and filled, there will be a charge of $15.00 for rewrites.
2. Medication refills can be requested over the phone to treat stable, chronic medical conditions that require ongoing medication (i.e. asthma, allergies, hypertension, or diabetes). Please note if you are out of refills you may be due for a follow up appointment. Refills will not be provided after hours or on the weekends. Please allow 72 hours for these refills to be completed.
3. Antibiotics will not be prescribed over the phone. If you feel you or your child may need an antibiotic, he/she will need to be seen.
4. Narcotics & controlled substances will not be called in. Patient **MUST** see the Doctor for an appointment to discuss these medications.

Others:

1. Medical records can be faxed to another physician free of charge for continuum of care and upon receipt of the medical records release. However, if the entire record is requested for changing of PCP or personal record a fee applied.
2. Patients may obtain a copy of their medical record for a fee. Our office will provide patients their medical record in a form of an USB flash drive. Patients may also request paper copies; however, an additional fee may apply due to the volume of their medical records.
3. An excused absence for school or work will only be issued if you or your child has been seen in the office for the illness. Note must be obtained at the time of visit.
4. There will be a $25.00 fee for any paperwork that requires the physician's signature.
5. Due to HIPPA laws patients must check in with the receptionist and are not allowed in the back office without consent.

____ ________________
Signature of Patient/Legally Authorized Representative   Date

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: ______________________ DOB: ______________________

ADDRESS: ______________________ PHONE: ______________________

CITY/STATE/ZIP: ______________________

This information is to be release:

FROM		**TO**	
PERSON/FACILITY:	______________________	PERSON/FACILITY:	______________________
ADDRESS:	______________________	ADDRESS::	______________________
CITY/STATE/ZIP:	______________________	CITY/STATE/ZIP:	______________________
PHONE:	______________________	PHONE:	______________________
FAX:	______________________	FAX:	______________________

INFORMATION TO BE DISCLOSED:

- ❑ Copy of all health records.
- ❑ Billing Records.
- ❑ SPECIFIC RECORDS:
  - Laboratory Tests____ X-Ray Reports____
  - Progress Notes____ Other_________________________

THE PURPOSE OF THIS DISCLOSURE IS FOR:

- ❑ Continuance of Medical care.
- ❑ Attorney
- ❑ Insurance
- ❑ Other:_______________________________________

❑ Records to be faxed or electronically transmitted?

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

______________________________ ______________
Signature of Patient/Legally Authorized Representative Date