REGISTRATION FORM
PLEASE PRINT

PATIENT INFORMATION

Legal Name: First: _____ MI_____ Last: _____

SSN: _____ DOB: _____ Age: _____ Sex (circle one): Male / Female

Parent/Legal Guardian Name: _____ DOB: _____ Mobile: _____

Title (circle one): Mr. / Mrs. / Ms. / Miss Marital Status (circle one): Single / Married / Divorced / Separated / Widowed

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Mobile: _____

Email Address: _____ ☐ No Email

Employment Status (circle one): Employed / Retired / Student / Unknown

Preferred Language: _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Unknown / Decline to answer

Race (can mark more than one; if multiracial): American Indian / African American / White / Native Hawaiian or other Pacific Islander Asian / Unknown / Decline to specify

Employer: _____ Occupation: _____

Referral Source (please circle one): Insurance Plan / Hospital / Family / Friend / Internet / Location / Physician / Other

Emergency Contact Information:
Name: _____ Relationship to Patient: _____ Phone Number: _____

Patient Portal: ____ Patient does want to receive access to health information. ____Patient does **not** want to receive access to health information.

INSURANCE INFORMATION

Person responsible for bill: _____ DOB: _____ Phone Number: _____

Address (if different): _____

Primary Insurance: _____ ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber SS #: _____ DOB: _____

Patient Relationship to Insured (circle one): Self / Spouse / Child / Other: _____

Secondary Insurance: _____ ID Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber SS #: _____ DOB: _____

Patient Relationship to Insured (circle one): Self / Spouse / Child / Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize West Frisco Health and Wellness and/or West McKinney Health and Wellness or insurance company to release any information required to process my claims.

Patient/Legal Representative's Signature Date

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician and/or other individuals he/she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical conditions. This consent is valid for each visit I make to West Frisco Health and Wellness and/or West McKinney Health and Wellness unless revoked by me in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to West Frisco Health and Wellness and/or West McKinney Health and Wellness infectious disease protocol); or 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of West Frisco Health and Wellness and/or West McKinney Health and Wellness if any of those situations occur during your treatment period.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Date

Relationship to Patient

Witness (*Office Staff)* Date

CONSENT FOR TREATMENT OF A MINOR (Ages 0-18th Birthday)

I give permission for *West Frisco Health and Wellness and/or West McKinney Health and Wellness* to provide confidential medical evaluation and treatment to the minor named above. I understand the care being rendered may include diagnostic testing, in office labs, surgical evaluation and contraceptive services. Additional diagnostic testing may be sent or requested from a third-party testing facility. It is understood this authorization is given in advance of any specific diagnosis, treatment or care being required. It provides authority and power to render care to above-mentioned by the staff of *West Frisco Health and Wellness and/or West McKinney Health and Wellness* in the exercise of their best judgment. I agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third-party payors who may be responsible for part or all the cost of the services provided. I declare under penalty of perjury that the above information is true and correct. My signature signifies that I have read and understand the content of this consent.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Date

Relationship to Patient

Witness (*Office Staff*) Date

CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and video, and Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded during telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. West Frisco Health and Wellness and/or West McKinney Health and Wellness has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform West Frisco Health and Wellness and/or West McKinney Health and Wellness of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize West Frisco Health and Wellness and/or West McKinney Health and Wellness to use telemedicine in the course of my diagnosis and treatment.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Date

Relationship to Patient

Witness (*Office Staff*) Date

FINANCIAL POLICY

Thank you for choosing West Frisco Health and Wellness and/or West McKinney Health and Wellness as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is patient responsibility to provide us with the most current insurance information at time of each visit.**
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. It is patient responsibility to know insurance benefits and whether or not the services rendered are covered benefits. Our offices have no way of knowing every insurance plan benefit; patient is responsible for knowing what services are or are not covered.
- We must emphasize that, as medical providers, our relationship is with the patient, and not the insurance company. Each insurance contract is between the patient, the insurance company and possibly the employer. It is patient responsibility to know and understand the level of services covered by the insurance company.
- If the insurance company does not respond to our claim, a statement will be sent to the patient. The patient will have to call the insurance company to work out the claim; our office will assist the patient only after the patient has contacted the insurance.
- Copayments, coinsurance and/or deductibles are **due at the time of service**. We will estimate the amount the patient owes based on information we receive from the insurance company. However, the patient is responsible for paying the full amount determined by the insurance company once they have paid the claim-regardless of our estimation. **Failure to keep the account balance current may require us to cancel or reschedule the scheduled appointment.**
- It is patient responsibility to provide us with the most current billing information such as address, phone number, and any other point of contact at each visit.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 90 days of the statement issue date are deemed past due. If the patient account is past due for an amount more than $200 (two hundred dollars), the patient will not receive services from any medical providers at West Frisco Health and Wellness and/or West McKinney Health and Wellness and can be dismissed from the practice. Failure to accept the certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
- We do understand that temporary financial problems may affect timely payments. We encourage you to communicate any such problems and ask about our "Agreement to Pay for Physician Services" Plan.
- In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $35.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
- The patient will be charged a "No Show" fee of $30 if they fail to cancel or reschedule the appointment at least 24 hours prior.

By signing this, you are agreeing to the clear understanding of our financial policy and how it is important to the relationship with West Frisco Health and Wellness and/or West McKinney Health and Wellness.

Patient's Printed Name Date of Birth

Patient/Legal Representative's Signature Date

Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to receive the Notice of Privacy Practices. This notice identifies how certain medical information about you may be disclosed. I understand West Frisco Health and Wellness and/or West McKinney Health and Wellness reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office.

Patient's Printed Name	Date of Birth
Patient/Legal Representative's Signature	Date
Relationship to Patient	

COMMUNICATION PREFERENCES

I wish to be contacted in the following manner: **(Please list phone number that is best number for staff to call)**

Telephone Number: _____

Please select one option:
- o Authorized to leave message with detailed information.
- o Leave message with call-back number only.

Email address: _____

Please select all that apply:
- o I authorize West Frisco Health and Wellness and/or West McKinney Health and Wellness to contact me using the email address provided above.
- o I understand my name, information regarding my account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted.

PATIENT AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION TO OTHERS

I authorize West Frisco Health and Wellness and/or West McKinney Health and Wellness to disclose or provide my protected health information to the following individual(s). This authorization will remain in effect until terminated by you, or other individual(s) of legal entity authorized to do so by court order or law. You have the right to modify or revoke this authorization by submitting a written request to our office.

Name/Relationship	Contact Phone Number
Name/Relationship	Contact Phone Number

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Legal Name (Print) _____ Patient Social Security Number _____ Patient DOB ____/____/____

_____ **(Initial)** I authorize *West Frisco Health and Wellness* and/or *West McKinney Health and Wellness* to obtain or disclose my health information as described below.

Please identify the information to be obtained or released (check one option):

☐ Please release my entire record

-OR-

☐ Please release ***only*** the following information (check appropriate boxes):

- ☐ Problem list
- ☐ Medication list
- ☐ List of allergies
- ☐ Immunization records
- ☐ Most recent history
- ☐ Most recent discharge summary
- ☐ Lab results (please describe the dates or types of lab tests): _____
- ☐ Imaging reports (please describe the dates or types of images): _____
- ☐ Consultation reports (please provide doctors' names): _____
- ☐ Other (please describe): _____

The identified information will be used for the following purpose (check one option)

- ☐ My personal records - ☐ pick up in office ☐ mail to address on file *fee will be charged*
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please *initial* each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be obtained from the following doctor/hospital/clinic:

Name: _____ Name: _____

Fax Number: _____ Fax Number: _____

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ ____/____/_____

Patient/Legal Representative's Signature Date

Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____

_____ ____/____/_____

Office Staff Signature Date

Distribution of copies: original to practice, copy to patient, copy to accompany information released.

West Frisco Health & Wellness

West McKinney Health & Wellness

Welcome to our practice. Please fill out the information below to the best of your ability.

Physician/Nurse Practitioner: _____ Date: _____

Patient Name: _____ Reason for Visit: _____

Personal Medical History			**Previous Surgeries/Serious Injuries (When?)**
Diabetes (Type _____)	N	Y: Date _____	_____
High Blood Pressure	N	Y: Date _____	_____
Cancer (Type_____)	N	Y: Date _____	_____
Stroke	N	Y: Date _____	_____
COPD	N	Y: Date _____	_____
High Cholesterol	N	Y: Date _____	_____
GERD	N	Y: Date _____	_____
Arthritis	N	Y: Date _____	_____
Gout	N	Y: Date _____	_____
Sleep Apnea	N	Y: Date _____	_____
Asthma	N	Y: Date _____	**Local Pharmacy**_____
Thyroid Disorder	N	Y: Date _____	_____
Allergic Rhinitis	N	Y: Date _____	**Mail Pharmacy**_____
Other	N	Y: Date _____	_____

Last Physical/Wellness Exam Date: _____

Patient Social History

Use of Alcohol:	Daily	Weekly	Monthly	Occasionally	Rarely	Never
Use of Tobacco:	Daily	Previously, but Quit	(Age Stopped_____)			Never
Use of Drugs:	Never	Type/Frequency _____				
Marital Status:	Single	Married	Divorced	Separated	Widowed	
Occupation:	_____					

Family Medical History

	Age	Diseases	If Deceased, Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son	_____	_____	_____
Daughter	_____	_____	_____

Patient Name: _____Date of Birth: _____

ALLERGIES (Medications and Dyes)	
Item(s) that you are *allergic* to:	**Reaction(s) you have had from the *medication*, you are allergic to:**

MEDICATIONS AND SUPPLEMENTS THAT YOU TAKE ON REGULAR BASIS			
Drug Name (Brand name, or generic name)	**Dosage**	**Times taken within 24 Hours**	**Reason for taking Medication**

Patient Name: _____Date of Birth: _____

Do you **currently** have any problems related to the following systems?

REVIEW OF SYSTEMS	
CONSTITUTIONAL: No Yes □ □ Chills □ □ Fatigue □ □ Fever □ □ Weight Gain □ □ Weight Loss	**GENITOURINARY:** No Yes □ □ Dysuria (painful urination) □ □ Hematuria (blood in urine) □ □ Urinary frequency
HEENT: No Yes □ □ Ear pain □ □ Eye pain □ □ Sinus pressure □ □ Sore throat	**INTEGUMENTARY (SKIN):** No Yes □ □ Hair loss □ □ Rash
RESPIRATORY: No Yes □ □ Cough □ □ Shortness of breath □ □ Wheezing	**NEUROLOGICAL:** No Yes □ □ Dizziness □ □ Extremity numbness □ □ Headache
CARDIOVASCULAR: No Yes □ □ Chest Pain □ □ Edema	**PSYCHIATRIC:** No Yes □ □ Anxiety □ □ Depression □ □ Insomnia
GASTROINTESTINAL: No Yes □ □ Abdominal Pain □ □ Blood in stools □ □ Constipation □ □ Diarrhea	**Musculoskeletal:** No Yes □ □ Back pain □ □ Joint pain □ □ Neck pain

Patient Name: _____Date of Birth: _____

Health Maintenance Flow Record

Test	Date Performed	Normal or Abnormal?
Bone Density		
Colonoscopy		
Eye Exam		
Foot Exam		
Echocardiogram		
Endoscopy		
EKG		
Spirometry		
Stress Test		

Male Patients Only

PSA Blood Test		

Female Patients Only

Mammogram		
Pap Smear		

Immunizations

Hep A vaccine	
Hep B vaccine	
Twinrix	
HPV vaccine	
Meningococcal vaccine	
MMR vaccine	
Pneumonia vaccine	
Tetanus vaccine	
Varicella vaccine	
Shingles vaccine	