Celina Medical Clinic

Patient Information

Please print clearly and complete all information requested. Thank you!

Patient Last Name _____ First Name _____

Mailing Address _____ City_____ State ____ Zip_____

Home # _____ Cell # _____ Work # _____

DOB _____ Sex: M F **Marital Status:** M S D W **Social Security # _____**

In case of emergency, please contact _____Relationship _____ Phone _____

How did you hear about us? (if there is someone who referred you please list their name so we know who to thank)

_____

Insurance Information

Insurance Name _____ Policy Holder Name _____DOB____/____/_____

Policy Holder's Mailing Address _____ City_____ State ____ Zip_____

Policy ID # _____ Group #_____

Do you have advanced directives (a living will)? YES NO If yes, where are they kept? _____

Office Policies

As our patient, Celina Medical Clinic is legally required to have certain patient information on file. This includes but is not limited to a current Texas driver's license, our Patient Information form completely filled out and current insurance card if filing with insurance today.

Payment for all professional services is expected at the time services are rendered, unless alternative arrangements have been made in advance. All deductibles and co-payments must be paid at the time of the office visit. Celina Medical Clinic does not file with Medicaid or CHIPs. Celina Medical Clinic does not file worker's compensation claims or motor vehicles accidents.

Services provided for a minor are the responsibility of the accompanying adult, regardless of custodial status. I understand it is the policy of this office to report any delinquent balances to the credit bureau. I authorize the release of any medical information necessary to process insurance claims and authorize payment of medical benefits to the party, which accepts assignment for the services rendered.

Due to the increase in medical documentation for other agencies, Celina Medical Clinic will charge a $25.00 fee for filling out those forms. Payment is required prior to the form being filled out. When requesting medication refills, please allow 24-48 hours for Celina Medical Clinic to respond.

I have completed this form fully, and I certify that I am the patient or the general agent or legal guardian of the patient duly authorized to furnish the information requested. I understand that I am fully responsible for payment of all services performed at the time they are rendered, with exceptions only as listed above.

If we are filing with insurance please understand that by signing below, you agree you are financially responsible for whatever insurance does not cover. I have received the Notice of Privacy Practices and the Celina Medical Clinic Financial Policy and I have been provided an opportunity to review it.

***Patient or Guardian Signature* _____**

***Patient or Guardian Printed Name* _____**

***Date* _____**

Health Questionnaire

Patient Last Name _____ **First Name** _____ **Date of Birth** _____

Current Medications

(List all medications you are currently taking, the dose, how often you are taking and **the reason you** are taking the medication. Include over the counter medication as well.)

Name / Strength / Reason _____ Name / Strength / Reason _____
Name / Strength / Reason _____ Name / Strength / Reason _____
Name / Strength / Reason _____ Name / Strength / Reason _____

Have you ever been treated for the following?

AIDS or HIV	**Y N**	Drug abuse	**Y N**	Measles or mumps	**Y N**
Alcohol abuse	**Y N**	Emphysema / COPD	**Y N**	Mitral valve prolapse	**Y N**
Anemia	**Y N**	Epilepsy / seizures	**Y N**	Mono	**Y N**
Anxiety	**Y N**	Esophageal reflux / heartburn	**Y N**	Pneumonia	**Y N**
Arthritis	**Y N**	Glaucoma	**Y N**	STD(s)	**Y N**
Asthma	**Y N**	Gout	**Y N**	Stroke	**Y N**
Bladder infections (frequent)	**Y N**	Heart attack	**Y N**	Substance abuse	**Y N**
Back pain (chronic)	**Y N**	Heart disease	**Y N**	Thyroid disease	**Y N**
Blood transfusion	**Y N**	Heart murmur	**Y N**	Tuberculosis or positive TB test	**Y N**
Cataracts	**Y N**	High blood pressure	**Y N**	Ulcer	**Y N**
Cancer (type) _____	**Y N**	Hernia	**Y N**	***Females only:*** Hysterectomy _____ (year)	
Cholesterol (high)	**Y N**	Hemorrhoids	**Y N**	***Females only:*** Date of last mammogram _____	
Chronic bronchitis	**Y N**	Hepatitis – A, B, C	**Y N**	***Females only:*** No. of pregnancies _____	
Chicken pox	**Y N**	Irritable bowel syndrome	**Y N**	***Females only:*** No. of c-sections _____	**Y N**
Colonoscopy – date: _____	**Y N**	Insomnia	**Y N**	***Females only:*** No. of miscarriages _____	
Crohn's disease	**Y N**	Kidney problems / stones	**Y N**	***Females only:*** Birth control method_____	
Depression	**Y N**	Leukemia	**Y N**	***Females only:*** Menstrual history/ Reg___ Irreg__	
Diabetes	**Y N**	Migraine headaches	**Y N**	***Females only:*** Date of last pap _____	

Allergies: medications, food, other

Name: _____ ***Reaction:*** _____
Name: _____ ***Reaction:*** _____
Name: _____ ***Reaction:*** _____

Surgeries

Year / Surgery	
Year / Surgery	
Year / Surgery	

Hospitalizations

Year / Illness	
Year / Illness	
Year / Illness	

Medical conditions in your family:

Father	Alive Deceased
Mother	Alive Deceased
Sibling 1	Alive Deceased
Sibling 2	Alive Deceased
Sibling 3	Alive Deceased
Paternal Grandfather	Alive Deceased
Paternal Grandmother	Alive Deceased
Maternal Grandfather	Alive Deceased
Maternal Grandmother	Alive Deceased

Social History:

Tobacco use: (any form)	No Yes
Alcohol:	No Socially Yes
Drug use:	No Yes
Children:	___ # sons ___ # daughters
Occupation	
Sexually active:	No Yes

Celina Medical Clinic

Financial Policy

Welcome to Celina Medical Clinic. Thank you for choosing us as your healthcare provider. In an effort to provide the best care possible, we would like to take a moment and explain a few of our policies.

Updating your Information: Please always make sure we have the most current demographic and insurance information on file for you. Filing claims with incorrect information delays processing and increases patient liability. Therefore, at check-in you will be asked to inform us of any changes to your demographic and insurance information. If you fail to give us updated insurance information at the time of your appointment, we will not be able to file your claim to the correct company after 30 days from the date of your visit.

Appointments: We understand that your time is valuable and we do our best to keep the schedule running smoothly and on time. Out of respect for all patients we ask that you be on time for each appointment. Any patient who arrives greater than 15 minutes past their scheduled appointment time will be asked to reschedule for a different day.

Should an emergency arise, we ask that you be patient as we do our best to handle the situation and return to seeing patients as scheduled. Unfortunately, it may be necessary for us to reschedule appointments unexpectedly. Should this occur, we will do our best to notify you as soon as possible and reschedule you at the next earliest time.

Should you need to cancel or reschedule any appointment, please contact the office as soon as possible; 24 hour notice is appreciated. Failure to notify the office prior to your scheduled appointment 3 times could result in being dismissed from the practice. A $25.00 no show fee may also be assessed. This fee is not payable by your insurance company and therefore will not be filed with insurance; the patient will be responsible for payment.

Preventative vs. Problem Visit: A preventative service, such as a well woman exam or physical, is a service provided to screen for various illnesses and diseases. A problem/sick visit is one when the patient has a specific concern, symptom, or complaint. Due to insurance carrier's requirements, we cannot see you for both preventative service and a problem/sick visit on the same day.

Non-covered Services: A non-covered service is any service that is denied by your insurance carrier due to benefit descriptions or limitations, policy exclusions, or pre-existing waiting periods. Non-covered services will be the responsibility of the patient and payment is due at the time of service. Please contact your insurance carrier and inquire about any service that may be non-covered. If you receive a service that is considered non-covered by your insurance plan, you will be expected to make payment in full for all charges.

Medicare: In an effort to help avoid unexpected expenses we would like to explain a little about Medicare.

1. Medicare only covers certain preventative services and applies frequency limitations to those services. Medicare will cover the collection of a pap smear and the breast and pelvic exam once every 24 months. If you choose to have these services more frequently, you will be responsible for payment. Keep in mind, whatever Medicare does not approve, then any supplemental insurance will not cover either.
2. Medicare never covers the office visit portion of an annual well women exam; the patient will be billed for this charge.
3. We are required by federal law and Medicare guidelines to charge all patients the same amount; therefore, we cannot discount any amounts not covered by Medicare. Should you have concerns about payment for your services, please speak with our billing department prior to your visit.

Payment: Our office attempts to verify all patients' insurance benefits prior to their appointment. Any co-pay, deductible, and/or co-insurance are due at the time of service. If you are unable to pay your portion at the time of your visit, we ask that you either reschedule your appointment or make prior financial arrangements with our billing representative. We will give you the best estimate possible based off of your benefits quoted. Please keep in mind, sometimes benefits are misquoted by your insurance carrier; however, we must collect based off their explanation of benefits. Once your insurance carrier has finalized your claim, we will make any necessary adjustments to your account.

Outstanding balances are due in full upon receipt of statement.

Claim Filing: It is important to remember that your insurance policy is a contract between you and your insurance company. We will do everything possible to assist you in getting your claim paid

Insurance: We are contracted with multiple insurance companies. Some insurance companies have special programs that allow for better benefits for you as the patient. While our providers may be contracted with the insurance company in general, they may not be a preferred provider under these special programs. We suggest you always verify with your insurance carrier to confirm there is nothing specific about your plan that would exclude our providers. It is important to remember that your insurance policy is a contract between you and the insurance company.

Secondary insurance plans can be of great assistance in the payment process. We will file deductible and co-insurance amounts to any secondary insurance you provide us; co-pays will not be filed to your secondary. Also, if you have multiple insurance carriers, please make sure each carrier is aware of the other and you provide us with accurate information. An insurance carrier in the patients name is always primary; you may not choose which carrier to use as primary vs. secondary.

Insurance Billing and Payment: In an effort to reduce patient financial liability, it is sometimes necessary for our billing department to appeal claims. In doing so, it may also be necessary to involve other agencies such as the Texas Medical Association and/or the Texas Department of Insurance. By signing this policy, you agree to allow us to release certain demographical and medical information to these agencies in order to secure payment. Please be assured we will only release information that is absolutely necessary.

Referrals/Authorizations: Should your insurance require a referral to another provider, please allow our office 72 hours to complete the referral. Under certain circumstances, you may be required to come and see the physician before a referral can be completed.

Phone Calls: While every phone call is important and we strive to answer all calls, there may be situations where the medical assistant cannot answer the call as they are with other patients. If this occurs please leave a detailed message and all calls left by 3:00 PM that day will be returned that day.

After Hours Care: In the event of an urgent matter or if your situation is an emergency, you need to call 911 and/or go to the nearest hospital emergency room or urgent care center.

Prescriptions: When you are due for a prescription, please contact your pharmacy and have them send over a refill request. Once we receive the refill request, we will review the prescription and either approve the prescription or notify you that we are unable to approve the prescription and will discuss your options with you at that time. Please allow 48-72 hours for prescription refills to be completed.

Prior Authorizations for prescriptions are required for certain insurance plans. If your insurance plan requires prior authorization, we will work as quickly as possible to complete it. Please keep in mind that some insurance plans take up to 3 weeks to complete their authorizations.

Labs: When you have blood work, pap smear, biopsies and/or cultures done we will send the specimens to an outside lab. Our preferred lab is LabCorp. Should you prefer an alternate lab, we will do our best to accommodate; however, you must inform the medical assistant prior to having your blood drawn. All lab tests will be billed by the laboratory. We do our best to forward the most current insurance information we have on file with each specimen. Occasionally this information does not forward properly. Should you receive a bill from the lab due to incorrect information, simply call the lab and provide your current insurance information. We do not have access to your laboratory billing account.

Returned Payment: Payment is accepted in the form of cash, money order, and/or credit card. Should a payment be returned for any reason, including but not limited to, insufficient funds, stop payment, or closed account, the patient will be liable for the original amount plus any associated NSF fees. Our current NSF fee is $25.00.

Refunds: Should your insurance process your claim differently than quoted or expected, any refund due to you will be issued only after all outstanding claims have been processed and there are no upcoming appointments within the next 3 months. This policy is designed to reduce administrative work associated with refunding money and subsequently billing for new balances. A patient with an account credit greater than an estimated amount due for a new service should not have additional monies collected, or only the difference between amount due and credit balance.

Medical Records: If you require copies of your medical records, please allow two weeks for processing the request. Furthermore, if you are requesting your records for yourself, there is a fee which must be paid prior to the records being copied and mailed. According the Texas State Board of Medical Examiners, the fee is $25.00 for the first twenty pages and $0.50 for each additional page. As a professional courtesy, we will provide records to another physician one time at no cost. If you request your records sent again within 6 months, charges as defined the Texas State Board of Medical Examiners will apply.

I have read, understand, and agree to the information and policies set forth in this agreement. I further agree that a photocopy of this agreement or an electronic signature is as valid as an original.

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patients Name	Date
Print Name of Legal Guardian, if applicable	

CELINA MEDICAL CLINIC

Authorization of Use and Disclosure of Protected Health Information

Person(s) Authorized to Receive Information:

Any health information created or retained by Celina Medical Clinic, PLLC may be disclosed to the following person(s):

Name	Relation
Name	Relation
Name	Relation

Use and Disclosure of Information

_____I authorize the person(s) listed above to receive all health information such as dates of services, type of services, treatment, payment for healthcare and/or other pertinent information regarding my healthcare provided by Celina Medical Clinic.

_____I do not authorize Celina Medical Clinic to disclose my health information to any party other than those listed in the *Notice of Privacy Practices*.

*This authorization will not expire unless it is revoked in writing by the patient or the patient's legal guardian.

May we leave a message on an answering machine or voicemail regarding appointments, your treatment, or other information pertaining to your healthcare and/or payment for your healthcare provided by Celina Medical Clinic?

_____YES _____NO

If "NO" how may we contact you with this information?

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patients Name	Date
Print Name of Legal Guardian, if applicable	