(FOR OFFICE USE ONLY) Patient Name: _____

Website: www.hallsvillemedicalclinic.com Phone # 903-668-7462

Patient Information: **(Please fill out every field completely. Circle Items in blue)**

First Name and M.I.		I II III IV V	Other:
Last Name		Jr Sr	
Mailing Address		Date of Birth:	
Address line 2			
City, State		Phone Number:	
Zipcode			
Sex: M F		Social Security Number	
Email Address			

Insurance information

(Disregard fields if they are completed above)

Insurance Name:	Insurance Phone:
Subscriber name:	Subscriber DOB:
Member ID:	
Group Name/Employer:	Group ID Number:
Relationship to Subscriber: Self Spouse Child Other:	
Concerns/Questions:	
How did you hear about us?	

I authorize release of my information in the event of an emergency to the following person: (If none, leave blank)

Emergency Contact Name:	
Emergency Contact Phone:	
Any Restrictions:	
Relationship:	

Signature*: _____ DATE: _____

(Signature of patient/responsible party)

Printed Name: _____Relationship to Patient _____

(FOR OFFICE USE ONLY) Patient Name: _____

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**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

HIPPA PROTECTED HEALTH INFORMATION – ACCESS FORM

I understand that stated and federal laws permit HALLSVILLE MEDICAL CLINIC to share Protected Health Information), with the persons involved in my care or the payment of my health care services. I further understand that I have (i) the right to grant certain persons access to my PHI and (ii) the opportunity to restrict access to my PHI from certain persons who might otherwise have access. I understand that granting access DOES NOT give the person access to copies of my medical records.

Access: I grant permission for the following persons to have access to my Protected Health Information.

NAMES (please print)	DOB	Phone Number

I understand that I may change or revoke this form at any time by contacting the Health Information Management Department (directly forwarded to the Business Office Administrator) at the Hallsville Medical Clinic office location. I understand that such changes or revocation will not be effective for disclosures that have already been made or access which has already occurred based on this form.

YES or NO You may leave confidential clinical information on my answering machine/voicemail.

Signature*: DATE: _____

(Signature of patient/responsible party)

Printed Name: _____Relationship to Patient _____

(FOR OFFICE USE ONLY) Patient Name: _____

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CONSENTS AND AGREEMENTS SIGNATURE

I UNDERSTAND THAT THE FOLLOWING PACKETS OF PAPERWORK WERE MADE AVAILABLE TO ME TO REVIEW BEFORE AND AT MY INITIAL NEW PATIENT VISIT. MY SIGNATURE BELOW INDICATES MY AUTHORIZATION OF THESE POLICIES IN REGARDS TO MY MEDICAL TREATMENT. I CAN REQUEST A COPY OF ANY/ALL OF THESE DOCUMENTS AT ANY TIME, AND I AM AWARE THEY ARE ALSO AVAILABLE FOR REVIEW ON WWW.HALLSVILLEMEDICALCLINIC.COM

- PATIENT CONSENT – (GIVING CONSENT TO RECEIVE TREATMENT AT THE CLINIC LOCATION, RELEASE/ACQUISITION OF INFORMATION, HEALTH INFORMATION EXCHANGE, HIPPA NOTICE OF PRIVACY PRACTICES)
- PATIENT AUTHORIZATION – (ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, AUTOMATED COMMUNICATIONS, OUTPATIENT DEPARTMENT)
- FINANCIAL POLICY – (AGREEMENT OF FINANCIAL RESPONSIBILITY, THE CLINIC'S RIGHT TO COLLECT PAYMENT FOR SERVICES, AND TO BILL INSURANCE IF ALLOWABLE)
- CLINIC CARE CONSENT – (GENERAL CONSENT, PERSONAL PROPERTY, RIGHTS AND ADVANCE DIRECTIVES, FINANCIAL ASSISTANCE, RELEASE OF INFORMATION, MEDICARE/MEDICAID BENEFITS, COMMUNICATIONS, ACCIDENTAL EXPOSURE AND STATE REPORTING, OWNERSHIP, PHOTOGRAPHY, ETHICS, TEACHING AND OBSERVATION, NOTICE OF PRIVACY PRACTICES, DIRECTORY, ASSIGNMENT OF BENEFITS, INSURANCE NETWORK, BALANCE BILLING DISCLOSURES)

(Requests for these documents can be made by email to hmc@hallsvillemedicalclinic.com or in person)

ACKNOWLEDGEMENT: By signing below, I certify that I have read this document, understand its contents and agree to the terms. I acknowledge that I am the patient, or I am the patient's legally authorized representative and/or Guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

Signature*: _____ DATE: _____

(Signature of patient/responsible party)

Printed Name: _____Relationship to Patient _____

**If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic.*

(FOR OFFICE USE ONLY) Patient Name: _____

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MEDICAL HISTORY

(please fill out in entirety- if you have questions, you can ask the MA, or PA-C)

Last Name:	First Name:	DOB:	M or F Other:
Marital Status: *(Circle)* Single Partnered Married Separated Divorced Widowed			Occupation:
Previous/Referring Doctor:			Date of last Physical: / /

Medications: Please bring all prescription medications you are currently taking

Name	Dose/Directions	Reason

(Additional room on back of next page if needed. A physical list is also a acceptable substitute)

Allergies	Reactions

Do you currently have, or have ever had, any of the following illnesses or conditions:

- **Anemia**
- **Anxiety/Depression**
- **Arthritis**
- **Asthma**
- **Atrial Fibrillation**
- **Blood Clots**
- **Cancer**
  - **Type: _____**
- **Heart Disease**
  - **Type _____**
- **Hepatitis/Liver Disease**
- **Hernia**
- **Neuropathy**
- **Osteoporosis**
- **Other injuries**
- **Peripheral Artery Disease**
- **Pneumonia**
- **Positive TB test**
- **Abnormal Pap**
- **Chronic Lung Disease**
- **Colon/Bowel Disease**
- **Diverticulitis**
- **Dementia**
- **Diabetes**
  - **(type I or II)**
  - **_____**
- **High Blood Pressure**
- **High Cholesterol**
- **Heart Murmur**
- **Infection of the uterus**
- **Prostate problem**
- **Psychiatric – Depression**
- **Psychiatric – Other**
- **Rheumatic Fever**
- **Seizures**
- **Sexually Transmitted Disease**
- **Alcohol/Drug use**
- **Gallbladder Disease**
- **Emphysema**
- **Heart Attack**
- **Glaucoma**
- **Head injury**
- **Gout**
- **Hay Fever**
- **Kidney Disease**
- **Migraines**
- **Sleep Apnea**
- **Stroke**
- **Thyroid Disease**
- **Tuberculosis**
- **Ulcer**

(FOR OFFICE USE ONLY) Patient Name: _____

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Surgical and Hospitalization History	**Dates**

Immunizations	Date	Immunization	Date		Date
Flu Vaccine		Zostavax (Shingles) Shingrex (Shingles)		Pneumococcal PPV23	
TDAP (Whooping cough/tetanus)		HPV		Hepatitis A	
Pneumococcal PCV13		Meningococcal ACWY		Hepatitis B	
Covid-19 *(type):*		Meningococcal B		TD (tetanus shot)	

Please list the names of physicians and specialists you have seen:

Name	Specialty	Name	Specialty

Item	**Date last performed**	**Result (if applicable)**	**Comments**
Aortic Aneurysm Screen			
Cholesterol Test			
Colonoscopy			
Dental Exam			
Eye Exam			
Hepatitis C Test			
HIV Test			
HPV Test			
Mammogram			
Pap Smear			
Prostate Exam			
Stool Test for Blood			

Family History (use back of page if needed) Please circle items in blue			**Age**	**Medical Conditions** Indicate Healthy or diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)
Mother		Living or Deceased		
Father		Living or Deceased		
Sibling	M or F	Living or Deceased		
Sibling	M or F	Living or Deceased		
Sibling	M or F	Living or Deceased		
Sibling	M or F	Living or Deceased		

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Grandmother (Mother's side)		Living or Deceased		
Grandfather (Mother's side)		Living or Deceased		
Grandmother (Father's side)		Living or Deceased		
Grandfather (Father's side)		Living or Deceased		
Children	M or F	Living or Deceased		
Children	M or F	Living or Deceased		
Children	M or F	Living or Deceased		
Other Family	Cancer	Heart Attacks	Stroke	Diabetes

Patient History

Smoking	Cigarette Use: Never Former Smoker Current Smoker	Date or Age quit: Other tobacco use (*please circle*): Pipe, Cigars, Chewing Tobacco Other: E-Cigarettes Marijuana
Alcohol	Do you drink Alcohol? YES or NO Frequency per month: Frequency per Week:	Each week, how many: _____ Servings of beer? _____ Glasses of wine? _____
Drugs	Have you used recreational or street drugs within the last two years? Yes or No Have you ever used recreational drugs with a needle? Yes or No	
Sexual Health	Sexually Active: Yes or No	Sexual Partners: Male Female
	# of children_____# of pregnancies____# of miscarriages____# of abortions____ Date of last menstrual period (start date): _____/_____/_____	
Women:		

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I HAVE GIVEN ABOVE IS ACCURATE, COMPLETE, AND TRUE.

Signature*: _____ DATE: _____

(Signature of patient/responsible party)

Printed Name: _____Relationship to Patient _____

**If the patient is unable to sign this agreement, or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient. The appropriate paperwork has been given by the patient to the Clinic*

HALLSVILLE
— MEDICAL CLINIC —

Patient Financial Policy

Thank you for choosing *Hallsville Medical Clinic* for your healthcare needs. We want to provide you with quality healthcare and a clear understanding of our Patient Financial Policy is vital to that relationship. Please ask if you have questions regarding our fees, policies, or your responsibilities.

_____**INSURANCE** – We participate in some but not all insurance plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

- If you are insured by a plan, we are credentialed with but don't have an up-to-date insurance card, or the benefits can't be verified, payment in full for the visit is required.
- If you are not insured by a plan, we are credentialed with payment in full is required at each visit, or you may request to be seen as a self-pay patient to have access to our reduced fee schedule. A claim will not be generated or filed in this situation.

_____**COPAYMENTS AND DEDUCTIBLES** – All copayments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.

- Failure for our office to collect, or for the patient to pay copayments/deductibles can be considered fraud.
- To make payments convenient we accept VISA, MasterCard, American Express, Discover, Care Credit, Cash, local checks.
- Please complete the Credit Card Authorization form attached.

_____**NON-COVERED SERVICES** – Please be aware that some or all of the services you receive may not be covered by your insurance plan. You will be required to pay for these services in full.

_____**PROOF OF INSURANCE** – All patients must complete all patient information forms before receiving healthcare services.

- We will need to obtain a copy of your driver's license and current valid insurance to provide proof of coverage.
- If you fail to provide us with the correct insurance information/identification, or order of coverage in the case of multiple policies, in a timely manner you will be responsible for the unpaid portion of the claim filed. Be sure to coordinate benefits with your insurance carriers so that you know which plan is primary and which is secondary.

_____**CLAIM SUBMISSIONS** – We will submit claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests.

- The balance of your claim is your responsibility regardless of if your insurance company pays the claim.

_____**COVERAGE CHANGES** – If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive maximum benefits. It is the policy holder's responsibility to provide our office with correct and current information for filing claims.

- If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____ **NON-PAYMENT** – It is our office policy that all past due accounts be sent 2 statements. If payment is not made on the account a single phone call will be made to collect the debt.

- If no resolution can be made the account will be sent for collection and could result in being discharged from the practice.

_____ **MINORS** – (less than 18 years of age)

- The parent or guardian is responsible for full payment and will receive a call from the office to make a payment over the phone if the minor presents without payment for the services.
- A signed release to treat a minor in the absence of the parent/guardian is required.

_____**SELF PAY ACCOUNTS** – Self pay accounts are for patient's without insurance coverage, patients with insurance plans in which the office does not participate, or patients without an insurance card on file.

- If a patient presents a self-pay status it is understood that an insurance claim will not be submitted to an insurance company.

Patient/Guarantor Signature _____ **Date** _____

Witness _____ **Date** _____

My initials and signature are evidence that I have read, understand, and agree with the financial policy of the Hallsville Medical Clinic.

CREDIT CARD AUTHORIZATION FORM

Credit Card Information

MasterCard VISA Discover AMEX CareCredit OTHER:

Card Number:

Expiration Date (mm/yy): **CVC :**

Cardholder ZIP Code (from credit card billing address):

I, _____ , authorize *Hallsville Medical Clinic* to charge the credit card above for the balance owed for the purchase of medical services. I understand that my information will be saved to file for future transactions on my account.

Customer Signature: **Date:**

Witness Signature: **Date:**

By signing this form, you, the patient or responsible party, give permission to Hallsville Medical Clinic to process payment for services provided and fees associated with the collection process. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.