Lone Star Clinic
Robert M Lenington MD, FACS, RVT
Morresa Bain FNP
Adam Fuller PA-C

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ City,State,Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ **Email Address:** _____

Date of Birth: _____ SSN: _____

Gender: *MALE* *FEMALE* Marital Status: *SINGLE* *MARRIED* *WIDOWED* *DIVORCED*

Race: _____ Ethnic Group: _____ Language Spoken _____

Primary Care Physician: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Named of SUBSCRIBER

Name: _____ Date of Birth: _____ SSN: _____

Employer of Subscriber _____ Employer Phone: Number _____

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION:

I am presenting the office of Lone Star Surgery with a copy of my insurance card(s) which contain all necessary information for billing purposes, authorizations for any/all procedures and imaging__(Initial)

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits including Major Medical and Medicare for services rendered by LONE STAR SURGERY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize said assignee to release all information necessary to process my insurance for payment. I authorize payment of medical benefits to LONE STAR SURGERY and understand that I am responsible for any balance that my insurance does not cover.

I do not have insurance and understand I am responsible for the total charges for any/all procedures and imaging. _____(Initial)

Signature: _____ Date: _____

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. FAMILY HISTORY

Family Member:	Stroke	High Blood Pressure	Diabetes	Heart Disease	Cancer/Type	Age of Death
Father	◊	◊	◊	◊	◊_____	_____
Mother	◊	◊	◊	◊	◊_____	_____
Brother/Sister	◊	◊	◊	◊	◊_____	_____
Brother/Sister	◊	◊	◊	◊	◊_____	_____
Brother/Sister	◊	◊	◊	◊	◊_____	_____
Maternal Grandmother	◊	◊	◊	◊	◊_____	_____
Maternal Grandfather	◊	◊	◊	◊	◊_____	_____
Paternal Grandmother	◊	◊	◊	◊	◊_____	_____
Paternal Grandfather	◊	◊	◊	◊	◊_____	_____

Other family medical problems:_____

Please list all of your Major Illnesses/Hospitalizations/Surgeries:

Illness/Hospitalization/Surgery:	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT INFORMATION:

Age:_____ Height:_____ Weight:_____

Doctor who referred you:_____Phone:_____

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CURRENT MEDICATIONS:

*Please list all **prescription** and over the counter (**non-prescription**) medications, including **vitamins** and **herbal supplements** that you are currently taking. Also, remember to include those that can cause bleeding (some examples are: Aspirin, Ibuprofen, Excedrin, Advil, Motrin, Aleve, etc., etc.)*

NAME OF MEDICATION	DOSE	HOW OFTEN

ALLERGIES

◊Peanut Allergy ◊Latex Allergy ◊Shellfish Allergy ◊NO Drug Allergies
◊Drug Allergies (please list/explain):_____

_____

REASON FOR YOUR VISIT

What is the main reason for your visit today?_____

What are your symptoms and when did they start?_____

TOBACCO/ALCOHOL USE

Do you now or have you ever used tobacco products (cigarettes cigars, chewing tobacco)? If so, how much:_____
Do you now or have you ever consumed alcohol products? If so, how much:_____

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MEDICAL HISTORY

Do you now, or have you recently experienced any of the following medical conditions/problems:

YES	NO	HEMATOLOGY
◊	◊	Blood transfusion
◊	◊	Easy bleeding
◊	◊	Bruising
		OPHTHALMOLOGY
◊	◊	Diminished vision
◊	◊	Eye irritation
◊	◊	Blurred vision
◊	◊	Loss of vision
		NEUROLOGY
◊	◊	Headache
◊	◊	Seizure
◊	◊	Memory Loss
◊	◊	Gait abnormality
		ENDOCRINOLOGY
◊	◊	Weight loss
◊	◊	Sleep disturbances
◊	◊	Cold intolerance
◊	◊	Heat intolerance
		CONSTITUTIONAL
◊	◊	Night sweats
◊	◊	Weight changes
◊	◊	Loss of appetite
◊	◊	Fever
		DERMATOLOGY
◊	◊	Rash
◊	◊	Moles
◊	◊	Lumps
◊	◊	Keloid formation
◊	◊	**PHYSCHOLOGY**
◊	◊	Bipolar
◊	◊	Depression
◊	◊	Tension/Stress/Anxiety
◊	◊	Suicidal ideation

YES	NO	ENT/RESPIRATORY
◊	◊	Shortness of breath
◊	◊	Cold
◊	◊	Cough/Sputum production
◊	◊	Sore throat
		CARDIOLOGY
◊	◊	DOE (dyspnea on exertion)
◊	◊	Chest pain
◊	◊	Murmur/Palpitations
◊	◊	Fatigue
		GASTROENTEROLOGY
◊	◊	Nausea
◊	◊	Heartburn
◊	◊	Vomiting
◊	◊	Difficulty swallowing
◊	◊	Abdominal pain
◊	◊	Constipation
◊	◊	Diarrhea
◊	◊	Changes in bowel habits
◊	◊	Blood in stool
		MUSCULOSKELETAL
◊	◊	Edema (Swelling)
◊	◊	Varicose veins
◊	◊	Arthritis
◊	◊	Leg cramps
		GENITOURINARY - MALE
◊	◊	Difficulty urinating
◊	◊	Increased urinary frequency
◊	◊	Hernia
		GENITOURINARY- FEMALE
◊	◊	Increased urinary frequency
◊	◊	Pelvic pain
◊	◊	Vaginal discharge
◊	◊	Hot flashes

Please explain all "YES" answers:_____

_____

Lone Star Clinic

RELEASE OF PATIENT INFORMATION CONSENT

In the event we are unable to reach you by phone and speak with directly to you, please check the *PREFFERED* method for our office to communicate with you:

_____ Leave a message on my answering machine or voicemail.

_____ Send notification in writing to my home address.

If you would like to assign others the privilege of accessing medical information, please indicate below the type of information accessible for each person:

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT	FULL DISCLOSURE	MEDICAL REPORTS ONLY	APPOINTMENT & SURGICAL INFORMATION

I understand that I may revoke or amend my consent for any individual listed above by providing such notice in writing to Lone Star Surgery, PLLC.

_____ _____ _____

Signature of Patient or Responsible Party | Relationship to Patient | Date

Lone Star Clinic

Consent to Use and Disclose Protected Health Information

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION?
Your protected health information will be used by Lone Star Clinic or disclosed to others for the purpose of treatment or supporting the day-to day healthcare operations of the practice.

THE NOTICE OF PRIVACY PRACTICES:
Lone Star Clinic is required to provide to you a notice that describes how information about you maybe used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies are defined in the "Notice of Privacy Policies and Practices" display in the front lobby/waiting area. **PLEASE REVIEW IT CAREFULLY.** If you need a copy of this notice, please chick with the front desk.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION:
You may request a restriction on the use or disclosure of your protected health information. However, Lone Star Clinic may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Lone Star Clinic agrees and fails to comply with your request. The restrictions requests will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the "Notice of Privacy Policies and Procedures", please consult with a practice representative.

YOU AMY REVOKE THIS CONSENT AT ANY TIME:
You may revoke this consent at any time; however, Lone Star Clinic requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of the request.

CHANGES TO PRIVACY PRACTICES:
Lone Star Clinic reserves the right to change or modify the privacy practice outline in the "Notice of Privacy Policies and Procedure". Lone Star Clinic will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

Signature:

I understand the "Notice of Privacy Policies and Procedures" and give my permission to Lone Star Clinic to use and disclose my health information in accordance with this consent and the notice provided.

_____ _____
Name of Patient (Printed) Signature of Patient Date

_____ _____
Patient Parent/Guardian/Representative Signature of Parent/Guardian/Representative

LONE STAR CLINIC

LONE STAR SURGERY FINANCIAL POLICY

It is the policy of Lone Star Surgery, PLLC to have a Financial Policy that clearly outlines patient practice financial responsibilities. Lone Star Surgery is committed to providing our patients with the best possible medical care while also minimizing administrative costs. The Financial Policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- It is the patient's responsibility to provide us with correct insurance and demographic information and to bring the insurance cards and a photo id to each visit.
- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance that we do not participate with their network, our office will be happy to file the claim upon request, however, payment is full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, co-payment, co-insurance or any portion of the charges as specified by the insurance plan at the time of the visit. Any medical services not covered by a patient's insurance policy is due in full at the time of the visit.
- Payment for professional services can be made with cash, check, debit card or credit card.
- Payment arrangements can be made for established patients. Balances must be paid on a monthly basis with payment made in full within six months with a pre-arranged payment plan. If a patient feels he/she may qualify for assistance, the practice receptionist should be notified for referral to the appropriate individual. Patients that do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made with us.
- It is the patient's responsibility to ensure that any required referrals for treatment is provided to the office prior to the visit. The patient may reschedule the appointment or accept financial responsibility due to the lack of referral.
- Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department which can be located on the insurance card.
- The adult accompanying a minor and the parents (or guardian of the minor) is responsible for payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by credit card, check, or cash has been paid at the time the service was scheduled.

Our practice believes that a good physician/patient relationship is based on understanding and good communication. Questions about financial arrangements should be directed to the physician's office. We are here to help you.

I understand the above information and agree to these terms.

Signature of Patient/Representative	Relationship to Patient	Date

LONESTAR CLINIC

Robert M. Lenington, MD, FACS, RVT
Tiffany S. Gebel, MD, FACOG

1216 Church Street
Sulphur Springs, TX 75482
Telephone: 903-885-2820
Fax: 903-885-2989

Billing
P.O. Box 1279
Sulphur Springs, TX 75483

www.lonestarsurgery.com

810 East Ralph Hall Parkway
Suite 140
Rockwall, TX 75032
Telephone: 972-961-4300
Fax: 972-961-4301

PAYMENT POLICIES

Please read and sign:

FOR EVERY OFFICE VISIT:

COPays are due in full at time of service

CO_INSURANCE AMOUNTS (usually 20%) are due in full at time of service

MEDICARE: Insurance will be filed with any balance billed to patient.

INSURANCE BENEFITS UNKNOWN: 20% of Charges are due in full at time of service

NO INSURANCE: Total visit amount is due in full at time of service

FOR EVERY OFFICE PROCEDURE AND OFFICE SURGERY:

CO-INSURANCE AMOUNTS (usually 20%) are due in full at time of Service

MEDICARE: Insurance will be filed with any balance billed to patient

INSURANCE BENEFITS UNKNOWN: 20% of charges are due in full at time of service.

NO INSURANCE: Total amount is due in full unless other prior arrangements have been made. Please ask to speak to Patient Care Coordinator.

OB PATIENTS:

Patient will be given an estimate for their OB care and payments are due at each appointment as listed on estimate.

SURGERY SCHEDULED:

SURGERY DEPOSIT is due 48 hour prior to surgery date or surgery is subject to be cancelled.
SURGERY DEPOSIT is based on the estimated patient balance owed.

ANY BALANCES REMAINING after the above amounts are collected will be billed to the patient.

I have read the above policy and agree to pay as stated.

_____ _____

Patient or Responsible Party Date

LONE STAR CLINIC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to Lone Star Clinic upon request in person or by mail to the address specified at the time of the request.

Provider: (name and address)	**Patient:** _____ **SS#:** **DOB:** _____

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ Admission history and physical
- ☐ Discharge summary
- ☐ Complete hospital chart
- ☐ Office notes
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Lab reports
- ☐ Radiological images
- ☐ Consultation notes or reports
- ☐ Complaints or grievances filed, with responses or dispositions
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me (These records should be redacted to protect information pertaining to other patients.)
- ☐ Other (specify): _____

Extent or nature of records to be released: _____
(example, specific hospitalization or visit)

This information will be used for the purpose of :

- ☐ Investigating an allegation of abuse
- ☐ Providing advocacy services
- ☐ Other activities at the request of the individual
- ☐ Verifying my eligibility for services offered by the Lone Star Clinic
- ☐ Legal representation

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider or to the facility, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Lone Star Clinic may redisclose the information.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____
Patient or Representative Date

_____
Name of Representative (print)

_____
Relationship to Patient