Lone Star Clinic

Tiffany S Gebel, MD, FACOG

PATIENT DEMOGRAPHICS

Last Name:_____ First Name:_____ MI:___ Birthdate:_____ SSN:_____

Address:_____ City/State/Zip:_____ Phone:_____ Email:_____

Male or *Female* |*Single Married Divorced Widowed* | Race:_____ Ethnicity _____ Language:_____

Occupation:_____ Religion:_____ Sexual Orientation: *Heterosexual Homosexual*

Emergency Contact:_____ Relationship:_____ Phone:_____

Insurance:_____ ID_____ Group:_____ Subscriber:_____

Subscriber DOB:_____ Subscriber Employer:_____ Subscriber SSN:_____

Primary Care Physician:_____ Phone:_____ Pharmacy:_____

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. _____(initial)

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

Signature:_____ Date:_____

Chief reason for today's visit:_____

GYNECOLOGIC HISTORY: First day of last menstrual period:_____ Date of last Pap Smear:_____

Type of birth Control currently using:_____ Are you happy with this method?:_____
(tubal ligation, condoms, abstinence, natural family planning methods, vasectomy)

Age of first period:_____ How many days do your periods last?_____ Do you have bad cramps? *Y/N*

Do you have any PMS symptoms? *Y/N* Any bleeding between periods? *Y/N* Any bleeding after intercourse? *Y/N*

How often do your periods come? ***Every 28-30 Days*** *Less Frequently More Frequently*

Any problems with loss of urination (while coughing, sneezing, etc.): *Y/N*

Check any of the following problems that you have had either in the past or currently: ☐ Gonorrhea ☐ Herpes ☐Pelvic Inflammatory Disease (PID) ☐Vaginal Infections ☐IUD Related Problems ☐History of physical or sexual abuse ☐Abnormal Pap Smears ☐HPV

OBSTETRICAL HISTORY: Are you currently pregnant? *Y/N* What date was your first positive pregnancy test? _____

Total number of pregnancies _____Total number of Miscarriages_____ Total number of Abortions _____

Total Number of Live Births:_____ Any complications during pregnancies?_____

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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):_____

_____

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:_____

Do you use recreational drugs? _____

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Medical History

YES	NO	MEDICAL ILLNESS
		High Blood Pressure
		High Cholesterol
		Hypertension
		Heart Disease
		Heart Bypass
		Heart Attack
		Stroke
		Blood clot or Pulmonary Emboli
		Arrhythmia
		Any form of Hepatitis or HIV
		Lupus
		Rheumatoid Arthritis
		Auto Immune Disease
		Fibromyalgia
		Trouble with urination
		Chronic Liver Disease
		Diabetes
		Thyroid Disease
		Arthritis
		Depression/Anxiet
		Physchiatric Disorder
		Cancer (Type)_____

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Please list:

Date	*Delivery Type*	*M/F*	*Length of Labor*	*Baby's Weight*	*Epidural?*	*Delivery Location/Doctor*
					Y/N	
					Y/N	
					Y/N	
					Y/N	
					Y/N	

Any family history of inherited disorders? (i.e. Tay Sachs, Spina Bifida, Down Syndrome, other genetic disorder? _____

MEDICAL HISTORY: How is your health in general? Excellent Good Fair Poor

Do you have any ***medical*** or ***psychological*** conditions? _____

Have you ever been hospitalized? Please explain. _____

Do you have a history of a bleeding disorder? *Y/N* Have you had a blood transfusion? *Y/N*

Have you had a mammogram? *Y/N* When? _____ Do you have any problems with your breasts (lumps, discharge)? *Y/N*

FAMILY HISTORY: Please check if anyone in your family has these conditions and specify who.

Breast Cancer	Colon Cancer	Heart Disease	Osteoporosis
Uterine Cancer	Diabetes	High Blood Pressure	Autoimmune
Ovarian Cancer	Thyroid Disease	Stroke	Other _____

Please use this area to further explain any pertinent information:

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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
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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 int eh "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

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LONE STAR CLINIC 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 _____

903-885-2820

Fax: 903-885-2989

Lone Star Clinic
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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 Surgery 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

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