healthONE FAMILY MEDICINE
www.healthONEmedicine.com
469.262.5762(p) • 469.262.5763(f)
3601 Regent Blvd. #165 Irving, TX 75063

New Patient Registration

Name (First, Middle, Last): _____

DOB (mm/dd/yyyy):_____ **Social Security Number**:_____

Street Address: _____

City: _____ **State**: _____ **Zip Code**: _____

Main Phone Number: _____ **Alternative Phone Number**: _____

Email: _____ **Sex**: ☐ Male ☐ Female

☐ I give permission for Health One Family Medicine to contact me via email for appointment reminders.

How did you hear about us? ☐ Friend/Family ☐ Internet ☐ Drive by ☐ Mailer ☐ Other

Emergency Contact Full Name: _____

Relationship: _____ Phone Number: _____

Marital Status (optional)
Married Single Divorced Widowed

Languages
Preferred: _____
Other: _____

Ethnicity (optional)
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

Primary Insurance Information
Insurance Plan: _____
ID/Certification No.: _____
Policy/Group No: _____
Policy holder (if other than patient)
Name: _____
DOB: _____
Address: _____
City: _____ State: _____
ZIP: _____ Sex: ☐ M ☐ F
Employer Name: _____

Secondary Insurance Information
Insurance Plan: _____
ID/Certification No.: _____
Policy/Group No: _____
Policy holder (if other than patient)
Name: _____
DOB: _____
Address: _____
City: _____ State: _____
ZIP: _____ Sex: ☐ M ☐ F
Employer Name: _____

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A fee for no shows may apply.

_____ _____
Patient Signature Date

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Health History

Please note, this information is for clinic use only and will not be share unless agree by you.

MEDICAL HISTORY

Have you ever had any of the following?

Heart Disease	☐	Sickle Cell Disease	☐	Mononucleosis	☐
Heart Murmur	☐	Blood Transfusion	☐	Gall Bladder Disease	☐
Rheumatic Fever	☐	High Cholesterol	☐	Kidney Problems	☐
Asthma	☐	Diabetes	☐	Mood Disorders	☐
COPD	☐	Cancer	☐	Depression	☐
Pneumonia	☐	If yes, what kind? _____		Anxiety	☐
High Blood Pressure	☐	Migraine	☐	Chronic pain	☐
Stroke	☐	Congenital Disease	☐	Arthritis	☐
Blood Clot in Vein	☐	Seizures	☐	Osteoperosis	☐
Rheumatological Disease	☐	Epilepsy	☐	Insomnia	☐
(e.g.) Lupus		Liver Disease	☐	Anemia	☐
Sleep Apnea	☐	Hepatitis	☐	Other _____	

Have you had any surgeries? Yes ☐ **No** ☐ If **yes**, please list:_____

Do you experience any of the following symptoms regularly?

Chest Pain ☐ Shortness of breath ☐ Vision Problems ☐ Dizziness ☐
Headaches ☐ Sensory Difficulties ☐ Pain ☐ (Where is the pain? _____)

Have you ever been admitted to a hospital? Yes ☐ **No** ☐ If **yes**, please complete below:

Date admitted _____ Hospital Name/Location _____
Reason for admission _____ No of days in hosp _____ Discharge diagnosis _____

FAMILY HISTORY

Do any of the following conditions run in your family (blood relatives only)?

Stroke	☐	Diabetes	☐
Heart Attack/Disease	☐	Genetic Condition	☐
High Cholesterol	☐	Breast Disease	☐
High Blood Pressure	☐		
Cancer	☐	Other _____	

If yes, what kind?_____

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐
If yes, how many times per day?_____

Do you drink alchohol? Yes ☐ No ☐
If yes, how many units per week?_____

Have you ever taken illegal drugs? Yes ☐ No ☐
If yes, which ones?_____

MEDICATION/ALLERGY HISTORY

List your current medications below:

Name	Dose	Frequency

List your allergies below:

Food/Drug Name	Reaction

This information is correct and up-to-date to the best of my knowledge.

Signature_____**Date**_____

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Consent for Treatment

Name of Patient: _____ Date of Birth: ___/___/___

Name of person giving consent if different from patient:

Name: _____ Relationship to Patient: _____

I, hereby and voluntarily consent to authorize Health One Family Medicine healthcare providers to provide healthcare services to me at all locations. The health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I also consent to authorize Health One Family Medicine to collect current and past medication history (Rx).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions.

I understand that this consent is valid and remains in effect as long as I am a patient of Health One Family Medicine, until I withdraw my consent, or until Health One Family Medicine changes its services and asks me to complete new consent forms.

My Signature on this form indicates that:

I certify that I have read and fully understand the foregoing consent and the facts indicated above are true.

1. I realize that although every effort will be made to keep all risks and side effects to minimum, risks, side effects and complications can be unpredictable both in nature and severity.
2. I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require such.
3. I hereby voluntarily give my consent to Treatment at Health One Family Medicine.

_____

Signature of Patient/Legal Representative Date

_____

Signature of Witness Date

_____

Name of Witness

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HIPAA: Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-today activities and management of Health One Family Medicine. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement.Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting.Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment reminders. Your health information will be used by our staff to remind you of future appointments.

Information about treatments. Your health information may be used to send you information the treatment and management of your medical condition. We may also send you information describing other health-related products and services.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

RIGHT TO REVISE PRIVACY PRACTICES

We reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information within our practice. Requests to Inspect Protected Health Information as permitted by federal regulation, your request to inspect or copy your protected health information must be submitted in writing. You may obtain a form to request access to your records by contacting the Office Manager or the Privacy Officer. Your request will be reviewed and will usually be approved unless there are legal or medical reasons to deny the request.

COMMENTS OR COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
3601 Regent Blvd #165 Irving, TX 75063

If you believe your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

DUTIES

It is our duty to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We must also abide by the privacy policies and practices outlined in this notice.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include: the right to request restrictions on the use and disclosure of your protected health information; the right to receive confidential communications concerning your medical condition and treatment; the right to inspect and copy your protected health information; the right to amend or submit corrections to your protected health information; the right to receive an accounting of how and to whom your protected health information has been disclosed; and the right to receive a printed copy of this notice.

Please read the following statements carefully: HIPAA regulations require that every patient at HOFM have a completed and signed Acknowledgment in the patient chart. This forms acknowledges you have been given the opportunity to read our Notice of Privacy Practices. This form must be completed only once while you are a patient at Health One Family Medicine.

You may read our Notice of Privacy Practices before you sign this form. Our Notice provides a description of our treatment, payment activities and healthcare operations; of the uses and disclosures we may make of your protected health information; and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our Privacy Officer at (469)262-5762. Please sign your acknowledgment.

I, _____, have had the opportunity to read and consider the contents of this form and your Notice of Privacy Practices.

_____ _____
Signature Date

_____ _____
Name of Gaurdian*(if applicable)* Relationship to Patient

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Financial Policy

Nowadays, most of our medical bills involve health insurance, which can be very complicated. We realize this, and our goal is to make things as simple as possible for you. We also ask for your assistance to simplify our processes. Here are our policies:

Please bring your insurance card to the office for every visit.
Always be sure to tell us right away when you get new insurance coverage. You must bring you insurance card on your first visit, as well as at any time your insurance coverage changes. It is your responsibility to determine that we are contracted providers before being seen. We are not responsible for changes in your insurance.

Please update your address, telephone, and employer information with us.
Please call our business office if your information changes before your next visit.

In-Network Insurance coverage
Many insurance providers offer a wide variety of plans or sub-products. It is your responsibility to determine that we are contracted providers with your exact insurance plan before being seen. While we are contracted with most major insurance providers, we may be out-of-network with some of its sub-products.

We are not responsible for laboratory billing.
Laboratory billing is separate to the physician bill you receive. We are not responsible for any laboratory billing issues that arise after the service provided. We can suggest labs as part of your annual checkup or medical conditions, but we do not provide any guarantee for its insurance coverage.

Health Savings Account / High Deductible Insurance Plan
We hold the right to collect an upfront amount before the service is provided. We will bill the insurance after the service is given; and the remaining amount, after the insurance adjustment, shall be the patient's responsibility.

We do not bill third-party insurance.
If you have been injured in an auto accident, you must tell the front office staff when you check in. You will be responsible for the payment in full at the time of service.

When your insurance delays payment.
If your insurance carrier does not make payment within 90 days, the balance will be due in full from you. If there is a problem or dispute over payment with the insurance carrier, this is a matter for you to pursue with them. If any payment is subsequently made by your insurance carrier in excess of the balance we estimated, we will promptly refund the credit amount to you.

When your insurance denies a claim.
If your insurance denies a claim, you will be billed for all services not covered in accordance with our insurance contracts. This may include, but are not limited to, denials due to eligibility, out-of-network services, not covered services, and maximum benefits have been reached.

Missed appointments and cancellation.
We want to be available to meet your health needs. If you must cancel or reschedule your appointment, please call us 24 hours in advance. There will be a missed appointment fee of $25 if we receive less than 24 hours advanced notice or if you fail to show up for your appointment.

Medical Records
There will be a charge for copying materials from your chart when done other than at the time of a visit including the transfer of records to another facility.

I have read and understand the above information. I also understand that no guarantees have been made to me about my insurance coverage; and I do not hold Health One Family Medicine, or any of its physicians or staff responsible for my insurance coverage, pre-authorization or other insurance decisions.

_____ _____

Name Patient/Guarantor Signature

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Financial Policy (cont'd)

Payment is due at the time of service.
If you cannot pay our copayment at the time of the visit, we will add a billing fee on top of the copayment. We will not bill secondary insurance plans for copays. A copay may be due regardless of whether you see a physician for an office visit; that is, if you have a nurse visit for an injection, there will be copay assessed by your insurance company for that visit. If you have a deductible that must be met each year before the insurance starts to cover the visits, please know what that deductible is, and pay for visit at the time of service. If we do not have confirmation that you are covered by an insurance plan, you will be expected to pay the charges in full at the time of the visit. When we receive an insurance payment, we will promptly refund you payment.

If you have no insurance, or if we are not able to verify your insurance eligibility, we ask that you pay for the visit at the time of service.
There may be times when you are between jobs or otherwise without health insurance coverage. There may also be times when your new insurance coverage has not yet registered with your insurance plan or the IPA. In these instances, we ask that you pay for the visit at the time of service. We will bill your new insurance. If they cover the claim, we will gladly refund you.

Payment options
For your convenience, we accept most major credit cards including Visa, MasterCard, Discover, American Express. Please make your checks to "Gruh Medical PLLC". If these options do not work for you, we can make arrangements to set up a payment plan. If you need this extra consideration, we ask that you set this up in advance with our office.

Medical Forms
There will be a charge for filling out forms when it is not done at the time of an appointment, including school forms, child care forms, and immunization cards. There is no charge for forms completed as part of an office visit.

Returned checks
There will be a banking fee of $25 for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order, or credit card.

Collection Agency Reporting Policy
You must notify us of any errors or objections to billing statements within (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If any balance on your account is over **60 days past due**, your account will be in default and may be referred to a collection agency.
Non-Payment on Account - Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand we have the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collections including, but not limited to: (1) late fees and charges due as a result of such delinquency; (2) all court costs and fees; (3) any collection fee to be charged under a separate agreement with a third-party collection agency, and to be added to the outstanding balance due and owing at the time of the referral to the third-party collection agency.

I have read and understand the above information. I also understand that no guarantees have been made to me about my insurance coverage; and I do not hold Health One Family Medicine, or any of its physicians or staff responsible for my insurance coverage, pre-authorization or other insurance decisions.

_____ _____

Name Patient/Guarantor Signature