Lakewood Medical Center

6243 Retail Road, Suite 500, Dallas, TX 75231 Office: 469-436-3901

HELPFUL INFORMATION BEFORE YOUR FIRST APPOINTMENT:

- Arrive 15 minutes prior to your appointment so we can complete the registration, before the provider can see you.
- Bring a valid photo ID.
- Be sure to bring your Insurance card, if you have Insurance.
- Co-Payments, Co-Insurances, and all other amounts are due at the time of service.
- Bring all medications you are taking to your appointment.
- Request appointments Online!

Visit our website at: www.LakewoodMedCenter.com

Thank you for choosing

Lakewood Medical Center

Keeping Dallas County Healthy

Lakewood Medical Center

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PATIENT REGISTRATION

Patient Information

First Name	Last Name	MI	Date Of Birth __ __/ __ __/ __ __
Address	City	State	Zip

Phone Number	Home	Work	Cell
Other Name(s) Used/Preferred		Email Address	

Gender ☐ Male ☐ Female	Social Security Number __ __ __ - __ __ - __ __ __ __	Driver's License	Employment Status

Marital Status	Preferred Contact	Preferred Language	Race
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Other _____	☐ English ☐ Spanish ☐ Other _____	☐ Native Indian / Alaskan ☐ Asian ☐ Black / African American ☐ White ☐ Hispanic / Latino ☐ Other _____

How did you hear about us?

Responsible Party (Guarantor) ☐ Same as Patient

First Name	Last Name	MI	Date Of Birth __ __/ __ __/ __ __
Address	City	State	Zip

Phone Number	Home	Work	Cell
Social Security Number __ __ __ - __ __ - __ __ __ __	Relationship to Patient	Driver's License	Preferred Language

Emergency Contact

First Name	Last Name	MI	Date Of Birth __ __/ __ __/ __ __
Address	City	State	Zip

Phone Number	Home	Work	Cell

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the providers and staff of the Lakewood Medical Center to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Lakewood Medical Center to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient/Responsible Party _____ **Date** _____

Name of Patient/Responsible Party (Print) _____ **Relationship to Patient** _____

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ASSIGNMENT OF INSURANCE BENEFITS/ELIGIBILITY CERTIFICATION

Primary Insurance Plan		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address		Phone #
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

For Medicare Patients Only		
Health Insurance Claim #	Part A Effective Date	Part B Effective Date

Other Insurance Coverage for Patient		
Patient Name	Date of Birth	
Insurance Plan	Group #	Policy #
Insurance Company Address		Phone #
Subscriber Name	Relationship to Patient	
Subscriber Certificate/Social Security #	Subscriber Date of Birth	
Subscriber Employer	Employer Phone #	
Employer Address		

☐ I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Lakewood Medical Center for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits or the benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

☐ I understand that I am eligible for benefits through my HMO policy. I understand that my assigned IPA/Medical Group chosen for my benefits is a Lakewood Medical Center affiliated medical group listed above. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me), will pay in full all such charges.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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OFFICE POLICIES & CONTACT PERMISSION

OFFICE POLICIES:

Because we are subject to the increasing demands of managed care, it has become necessary to alter our office policies. Our office policies are as follows:

1. **No Results of test are given over the phone.** We value our patients and to give the best care possible, we prefer our patients follow up on all abnormal results. This is required to ensure that patients understand the results and to discuss further treatment and do the additional diagnostic test as necessary. Abnormal results will not be given over the phone.

2. **Return phone calls.** It is very difficult for Providers to return phone calls during regularly scheduled hours. Allow up to 24 hours for us to return your phone calls with the exception of emergencies. We do not bill for any phone calls as it is a courtesy to our patients. **If you are experiencing a life-threatening situation, please call the emergency room for immediate assessment.**

3. **Late arrivals.** Patients that arrive late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first.

4. **Insurance** is filled as a contractual agreement and as a courtesy. However, if the Insurance Company does not pay within 90 days, the patient becomes responsible and the patient will be billed.

CONTACT PERMISSION:

We would like permission to use your email and/or your cellular telephone number in order to provide future appointment confirmations, office appointments, newsletters, educational articles, and/or other information from Lakewood Medical Center.

I understand that the above information will be kept private and confidential, and I give permission for Lakewood Medical Center to email and/or text me as needed.

Patient Name: _____ Date of Birth: _____

Email Address: _____ Cell Phone: _____

Patient Signature: _____

I have read and understand the policies described above.

Patient Signature: _____ Date: _____

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FINANCIAL POLICY

All patients must read and sign this form prior to receiving services.

Thank you for choosing Lakewood Medical Center as your health care provider. We are committed to the successful treatment of your condition. Your clear understanding of our Financial Policy is important to our relationship. Please call our billing department if you have any questions, they may be reached at 469-436-3901.

INSURANCE (PPO/POS/Commercial/Medicare Advantage Plans): All co-payments or co-insurance is due at the time of service. We are members of most, but not all, plans. You are responsible for verifying that we are providers for your plan. You are responsible for co-payments, deductibles and co-insurances on your plan. We maintain the right to collect payment towards patient responsibility prior to any treatment. If applicable, you will be directed to speak to a patient representative. You are responsible or any service denied by your insurance as a non-covered service.

HMO INSURANCE: All co-payments are due at time of service. We will assist with referrals as directed by your plan.

MEDICARE: We do accept Medicare assignment. As a Medicare patient, you are responsible only for the difference between the approved amount and the amount that Medicare pays, and of course, your deductible. If you have supplemental insurance, please provide a copy of the card and we will bill it for you. You will receive a bill after your insurance has paid if there is any remaining balance.

SELF PAY: Payment is due in full at the time of service. If you are unable to pay your balance in full, you must see a patient representative to make other arrangements.

TREATMENT FOR A MINOR CHILD: A parent or legal guardian must accompany patients who are minors (under 18 years of age). This accompanying adult is responsible for payment of the account, according to policy outlined above.

RETURNED CHECK: A $35.00 charge will be added to your account for any check returned by your bank for any reason.

DISABILITY & INSURANCE FORMS: There will be a charge of $40.00 for the completion of medical / disability / FMLA forms. Payment is due before paperwork is processed.
Please allow 7-10 days for completion of these forms.

LAB SERVICES: The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.
It is your responsibility to provide us with your most current insurance information.

BEFORE RECEIVING SERVICES, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

COPAYMENTS, COINSURANCE AND/OR DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

STATEMENTS: We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call 469-436-3901. Payment in full is due upon receipt of the statement. If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.

Failure to keep your account balance current may require us to cancel or reschedule your appointment. Full payment is due at the time of service. We accept cash, checks and credit cards. I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment of all services.

Patient Name: _____

Patient Signature (or Responsible Party): _____ Date: _____

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CONSENT TO TREATMENT AND RIGHT TO REFUSE TREATMENT

General Consent to Treatment:

By signing below, I, (or my authorized representative on my behalf) authorize Lakewood Medical Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

Right to Refuse Treatment:

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

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COMMUNICATING WITH YOU

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your provider's office. We may communicate with you through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.

Please check all boxes that you give Lakewood Medical Center permission to use for your communications:

- ☐ You may contact me by telephone — Phone Number: _____
- ☐ You may leave a message/voice mail — Phone Number: _____
- ☐ You may contact me by mail
- ☐ You may contact me through email — Email Address: _____

If you give permission for us to communicate with anyone else, please complete the list below:

	Name	Relationship	Phone Number	Options
1.				☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.				☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.				☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Signature of Patient/Responsible Party _____ **Date** _____

Name of Patient/Responsible Party (Print) _____ **Relationship to Patient** _____

Preferred Pharmacy

Pharmacy Name: _____ **Phone:#** _____

Pharmacy Address: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Presents this Notice

This Notice describes the privacy practices of ***Lakewood Medical Center*** and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Practice. The Practice and the individual health care providers together are sometimes called "the Practice and Health Professionals" in this Notice. While the Practice and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Practice and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at the Practice as a Practice patient or any other services provided to you in a Practice affiliated program involving the use or disclosure of your health information.

Privacy Obligations

The Practice and Health Professionals each are required by law to maintain the privacy of your health information ("Protected Health Information" or "PHI") and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. The Practice and Health Professionals use computerized systems that may subject your Protected Health Information to electronic disclosure for purposes of treatment, payment and/or health care operations as described below. When the Practice and Health Professionals use or disclose your Protected Health Information, the Practice and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures Without Your Written Authorization

In certain situations your written authorization must be obtained in order to use and/or disclose your PHI. However, the Practice and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, may be used and disclosed to treat you, obtain payment for services provided to you and conduct "health care operations" as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you-for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI may also be disclosed to other providers involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because if you do, this may impact your recovery.

- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you-for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("Your Payor") to verify that Your Payor will pay for health care. The physician who reads your x-ray may need to bill you or your Payor for reading of your x-ray therefore your billing information may be shared with the physician who read your x-ray.

- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be used to evaluate the quality and competence of physicians, nurses and other health care workers. PHI may be disclosed to the Practice Compliance & Privacy Office in order to resolve any complaints you may have and ensure that you have a comfortable visit. Your PHI may be provided to various governmental or accreditation entities such as the Joint Commission on Accreditation of Healthcare Organizations to maintain our license and accreditation. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Practice and Health Professionals.

Use or Disclosure for Directory of Individuals in the Practice. The Practice may include your name, location in the Practice, general health condition and religious affiliation in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or minister, even if they do not ask for you by name. If you do not wish to be included in the facility directory, you will be given an opportunity to object at the time of admission.

Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you who is involved in your health care or helps pay for your care. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Practice and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Practice and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition.

Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. For example, your PHI may be disclosed to identify or locate a suspect, fugitive, material witness, or missing person or to report a crime or criminal conduct at the facility.

Correctional Institution. You PHI may be disclosed to a correctional institution if you are an inmate in a correctional institution and if the correctional institution or law enforcement authority makes certain requests to us.

Business Associates. Your PHI may be disclosed to business associates or third parties that the Practice and Health Professionals have contracted with to perform agreed upon services.

Decedents. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

Specialized Government Functions. Your PHI may be disclosed to units of the government with special functions, such as the U.S. military, the U.S. Department of State under certain circumstances such

as the Secret Service or NSA to protect, for example, the country or the President.

Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories; such as required by the FDA, to monitor the safety of a medical device.

Appointment Reminders. Your PHI may be used to tell or remind you about appointments.

Fundraising. Your PHI may be used to contact you as a part of fundraising efforts, unless you elect not to receive this type of information.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Use or Disclosure with Your Authorization. For any purpose other than the ones described above, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided to you in a face-to-face encounter without obtaining Your Marketing Authorization. The Practice and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization). The Practice and/or Health Professionals may communicate with you in a face-to face encounter about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without Your Marketing Authorization.

In addition, the Practice and/or Health Professionals may send you treatment communications, unless you elect not to receive this type of communication, for which the Practice and/or Health Professionals may receive financial remuneration.

Sale of PHI. The Practice and Health Professionals will not disclose your PHI without your authorization in exchange for direct or indirect payment except in limited circumstances permitted by law. These circumstances include public health activities; research; treatment of the individual; sale, transfer, merger or consolidation of the Practice; services provided by a business associate, pursuant to a business associate agreement; providing an individual with a copy of their PHI; and other purposes deemed necessary and appropriate by the U.S. Department of Health and Human Services (HHS).

Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental illness, mental retardation and developmental disabilities; (3) is about alcohol or drug abuse or addiction; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s), including venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Practice and Health Professionals are not required to agree to these requested restrictions.

You may also request to restrict disclosures of your PHI to your health plan for payment and healthcare operations purposes (and not for treatment) if the disclosure pertains to a healthcare item or service for which you paid out-of-pocket in full. The Practice and Health Professionals must agree to abide by the restriction to your health plan EXCEPT when the disclosure is required by law. If you wish to request additional restrictions, please obtain a request form from the Practice and submit the completed form to the Practice. A written response will be sent to you.

Right to Receive Confidential Communications. You may request, and the Practice and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your PHI, except to the extent that the Practice and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Practice identified below.

Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Practice and Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. If you desire access to your records, please obtain a record request form from the Practice and submit the completed form to the Practice. If you request copies of paper records, you will be charged in accordance with federal and state law. To the extent the request for records includes portions of records which are not in paper form (e.g., x-ray films), you will be charge the reasonable cost of the copies. You also will be charged for the postage costs, if you request that the copies be mailed to you. However, you will not be charged for copies that are requested in order to make or complete an application for a federal or state disability benefits program.

Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Practice and submit the completed form to the Practice. Your request will be accommodated unless the Practice and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

Right to Receive an Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged for the accounting statement.

Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

For Further Information or Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Practice Compliance & Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Practice Compliance & Privacy Office will provide you with the correct address for the Director. The Practice and Health Professionals will not retaliate against you if you file a complaint with the Practice Privacy Office or the Director.

Effective Date and Duration of This Notice

Effective Date. This Notice is effective on **September 23, 2013.**

Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Practice and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Practice and on our Internet site. You also may obtain any new notice by contacting the Practice Compliance & Privacy Office.

Practice Compliance and Privacy Officer
C/O Practice Manager
6243 Retail Road, Suite 500
Dallas, TX 75231

Lakewood Medical Center

Lakewood Medical Center

6243 Retail Road, Suite 500, Dallas, TX 75231 Office: 469-436-3901

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Your name and signature on this form indicates that you have received a copy of **Lakewood Medical Center** Notice of Privacy Practices on the date and time indicated below.

If you have any questions regarding the information contained in **Lakewood Medical Center** Notice of Privacy Practices, please contact the Lakewood Medical Center Chief Compliance Officer at 469-436-3901.

Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Date Received: _____ **Time Received:** _____

FOR FACILITY USE ONLY

We attempted to obtain written acknowledgement of patient's receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained from the patient for the following reason:

- ☐ Individual Refused to Sign
- ☐ Emergency Situation Prevented Signature
- ☐ Patient Requested Above Individual Sign on His/ Her Behalf
- ☐ Other (please specify) _____

Registration Representative Signature: _____ Date: _____

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MEDICATIONS LOG

Patient Name: _____ **Date:** _____

Use this form to list the name of each medication you are taking, its dosage and timing. List all prescription medications and all over-the-counter medicines, including vitamins or other nutritional supplements, pain relievers, antacids, laxatives, and herbal remedies.

Name of Medication	Dose	Time(s) of day
Example: Synthroid 125 mcg	*1 tablet daily*	*7 AM*

List Any Drug Allergies: _____