Kofo Ekadi, M.D.
Board Certified
Internal Medicine

Adult Medicine

Well Physicals

Preventive Health Services

School/Sports Physicals

Preventive Care Procedures

Hello,

On behalf of the staff of Delta Medical Clinic, I would like to take this opportunity to welcome you to our practice. I am delighted you have chosen our Board Certified physician to care for you or your loved ones. We are all personally committed to providing the highest quality care and exceptional customer service for you and your family.

Our physician has over 10 years of experience practicing Internal Medicine in various settings. The combination of experience and know-how enables us to provide unparalleled service in our two locations (Fort Worth/Burleson and Cleburne). We have deployed online tools and electronic medical records systems to increase your access to care. We will continue to incorporate additional Information Technology (IT) services. Our current IT systems allow you to make appointments, request prescription refills, download forms online, and to communicate with the practice by email for non urgent concerns. Visit our web site at **www.delta-medical.com** from time to time to explore available features and other information. You may also call **817-293-8797** (Burleson Clinic) or **817-293-8797** (Cleburne Clinic) for appointments and other services.

Thank you for choosing Delta Medical Clinic physician.

Sincerely

Paul Ekadi, *MCSE, MSIS*
Practice Administrator

BURLESON
12001 South Freeway,
Suite 210
Fort Worth, TX 76028
Phone: (817) 293-8797
Fax: (817) 293-8793

www.delta-medical.com

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Delta Medical, P.A.
Acknowledgement of Receipt of
Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that Delta Medical, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website (**www.delta-medical.com**) and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Patient/Legal Representative Signature Date

_____
Relationship to Patient

_____ _____
Witness Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for and its affiliated companies to share my protected health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

RELEASE OF PERSONAL MEDICAL INFORMATION TO PATIENT

I wish to be contacted in the following manner (check all that apply)

Home Telephone_____

☐ O.K. to leave message with detailed information

☐ Leave message with callback number only

Work Telephone _____

☐ O.K. to leave message with detailed information

☐ Leave message with callback number only

Written Communication:

☐ O.K. to mail to my home address

☐ O.K. to mail to my work/office

☐ O.K. to fax to this number_____

☐ O.K. to e-mail this address: _____

Information about me may be released to (check all that apply and give name(s) of chosen individuals)

☐ Spouse_____
☐ Child_____
☐ Brother_____
☐ Sister_____
☐ Father_____
☐ Mother_____

_____ Date____/____/_____
Patient Signature

_____
Print Name

DELTA MEDICAL CLINIC
12001 S. Freeway Ste 210, Burleson, TX 76028
Phone: **(817) 293-8797**

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY **PHYSICIAN NAME:** _____

LAST NAME:	**FIRST NAME:**	MI:	FORMER NAME:
Address:		**City, State, and Zip:**	
HOME TEL: ( )	**CELL. PHONE:** ( )	**WORK TEL:** ( )	**EMAIL:**
MARITAL STATUS: ☐M ☐W ☐S ☐D ☐SEP.	**SEX:** ☐**MALE** ☐**FEMALE**	**SOCIAL SECURITY#**	**DATE OF BIRTH:** / **DRIVERS LICENSE:**
PATIENT'S EMPLOYER:		**EMPLOYER'S ADDRESS:**	
SPOUSE/Guardian (If under 16):	**WORK TEL:** ( )	**DATE OF BIRTH**	**SOCIAL SECURITY#**
EMPLOYER:		**ADDRESS:**	
EMERGENCY CONTACT:	**RELATIONSHIP:**	**PHONE# :** ( )	

PRIMARY INSURANCE COVERAGE

(PRESENT INSURANCE CARD AND DRIVERS LICENSE TO MEDICAL ASSISTANT)

INSURANCE COMPANY	**INSURED DOB**	**RELATIONSHIP** ☐SELF ☐SPOUSE ☐PARENT ☐OTHER _____	
NAME OF INSURED	**COPAY AMOUNT**	**ANNUAL DEDUCTIBLE**	**EFFECTIVE DATE**
INS. POLICY NUMBER	**GROUP NUMBER**	**INSURED'S SOCIAL SECURITY#**	
INSURED'S EMPLOYER	**PHYSICIAN LISTED ON INS. CARD**		
INSURANCE CLAIMS ADDRESS	**INSURANCE PHONE#**	**INS. LECTRONIC BILLING ID (THIN)**	
CITY	**STATE**	**ZIP**	

SECONDARY INSURANCE COVERAGE

(WE DO NOT FILE SECONDARY INSURANCE CLAIMS AT THIS OFFICE)

(LINK YOUR SEC. INS. WITH YOUR PRIMARY FOR CO-ORDINATION OF BENEFITS)

INSURANCE COMPANY	**INSURED DOB**	**RELATIONSHIP** ☐SELF ☐SPOUSE ☐PARENT ☐OTHER _____	
NAME OF INSURED	**COPAY AMOUNT**	**ANNUAL DEDUCTIBLE**	
INS. POLICY NUMBER	**GROUP NUMBER**	**INSURED'S SOCIAL SECURITY#**	
INSURED'S EMPLOYER			
INSURANCE CLAIMS ADDRESS	**INSURANCE PHONE#**		
CITY	**STATE**	**ZIP**	

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ☐PATIENT_____ ☐PHYSICIAN_____ ☐HOSPITAL ☐YELLOW PAGES-AT&T ☐YELLOW PAGES-VERIZON ☐INTERNET ☐POSTCARD ☐OTHERS_____

Guarantee of Payment and Assignment of Insurance Benefits

For value received, the undersigned guarantor (hereinafter "the Undersigned") and/or patient (hereinafter "the Patient") promises to pay Dr. Kofoworola Ekadi or Delta Medical PA (hereinafter "Provider") all charges incurred for services rendered to the Patient. The Undersigned understands that Provider will process the paperwork to complete insurance claim(s) as a courtesy to the Undersigned, and the Undersigned and/or the Patient authorize Provider to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to said Provider. It is, however, understood and agreed that the Undersigned is responsible for all monies due and owing for services rendered by Provider in the event insurance does not pay for these services. It is acknowledged that completing and following-up of any insurance claims is ultimately the responsibility of the Undersigned. It is further agreed by the Undersigned that in the event any monies received by Provider from the insurance carrier are at any time after their receipt withdrawn from Provider by the insurance carrier, the Undersigned will be responsible for those monies then due and owing, and waives any defense for payment the Undersigned may have against Provider. In the event this account is turned over to an attorney for collection, the Undersigned hereby agrees to pay all costs of collection, not limited to court costs but including reasonable attorney's fees. The Undersigned and/or Patient authorize use of this form of all insurance claim submissions. A photocopy of this assignment is to be considered as valid as the original. Your signature indicates you have read the above and agree to the terms contained therein. This agreement is irrevocable.

Signature _____ Date___/___/____

DELTA MEDICAL CLINIC

MEDICAL HISTORY FORM

Thank you for filling this form completely and accurately.
The information will of course, remain confidential and help us serve you better.

DATE TODAY: _____

NAME:_____ _____
LAST FIRST M.I. Date of Birth AGE

MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOWED ☐SEPARATED ☐DIVORCED **SEX:** ☐MALE ☐FEMALE

OCCUPATION:

REASON FOR VISIT TODAY:

Specialists you are seeing: Name_____ Reason_____ Phone number_____
Name_____ Reason_____ Phone number_____
Name_____ Reason_____ Phone number_____

Past History

Please Check the box (**X**) next to the illness you are either being treated for presently or had in the past:

( ) Diabetes Mellitus	( ) Pneumonia	( ) Tuberculosis	( ) Rheumatic
( ) Fever	( ) Visual problems/ glasses	( ) Headaches/dizziness	( ) High cholesterol
( ) Hypertension	( ) Anemia (low blood count)	( ) Goiter	( ) Stroke
( ) Heart attack	( ) Hepatitis	( ) Peptic ulcer disease	( ) Congestive heart
( ) Congestive heart failure	( ) Parkinson's disease	( ) Hearing loss	( ) Emphysema
( ) Bronchitis	( ) Asthma	( ) Fractures	( ) Seizures
( ) Skin problems	( ) Gallstones	( ) Blood clots	( ) Gonorrhea/herpes/warts
( ) Hemorrhoids/rectal bleeding	( ) Arthritis	( ) Psychological problems	

( ) Cancer (where)_____ ( ) Other problems _____
_____

Gynecological History: (FEMALES ONLY)

Menses (age of onset): _____ **Cycles:** ( ) regular ( ) irregular **Duration:** (number of days): _____
Menses (Characteristics): ( ) Scant ( ) Moderate ( )Heavy Cessation of menses age): _____
( ) Dysmenorrhea (cramping) ( ) Vaginal discharge/itching ( ) Bleeding between periods
( ) History of ovarian cysts uterine fibroids premenstrual syndrome sexual problems

Present birth control method (type and number of years used)_____ Previous methods_____

Number of pregnancies_____ Number of deliveries_____

Complications during pregnancy with ( ) High blood pressure ( ) High blood sugar (gestational diabetes)

Surgery

(IF YES, PLEASE CHECK (**X**) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( ) Appendectomy_____	( ) Cataracts_____	( ) Heart Stent _____	( ) Hysterectomy_____
( ) Breast Biopsy_____	( ) Hip Replacement_____	( ) Heart Bypass_____	( ) Mastectomy_____
( ) Ovary R_____ L_____	( ) C-section_____	( ) Knee Replacement_____	( ) Prostate Removal_____
( ) Carotid Artery_____	( ) Gallbladder_____	(Hernia Repair_____	( ) Stomach Surgery_____
( ) Tonsillectomy_____	( ) Lap Band _____	( ) Others: _____	

DELTA MEDICAL CLINIC

MEDICAL HISTORY FORM **Page 2**

DATE TODAY: _____

NAME:_____ _____
LAST FIRST M.I. Date of Birth AGE

Medications

LIST ALL CURRENT MEDICATIONS (INCLUDING ONES NOT PRESCRIBED, such as alternative agents or herbal agents)
Please know what drugs and doses you take; if you need refills let the nurse know when she places you in the exam room.

DRUG	STRENGTH	NUMBER OF TABLETS AND HOW OFTEN	LENGTH OF TIME YOU HAVE TAKEN
i.e. Aleve	220mg	Two tablets 2 times per day	6months

You may attach additional sheets if needed.

Pharmacy Name:_____ **Pharmacy Telephone**:_____ **Pharmacy Fax**:_____

Allergies (drugs, X-Ray Dye, tape, latex, Food): Please explain type of reactions e.g. hives, wheezing, upset stomach, swelling

_____
_____
_____

Family History

Check the box **(X)** next to the condition that you your family member has; then specify their relation to you after the disease, using the abbreviations as follows: Mother **(M)** Father **(F)** Brother **(B)** Sister **(S)** Grandparent **(GP)** Aunt **(A)** Uncle **(U)**.

For example, if your aunt and mother had breast cancer: (**X**) Breast cancer **A, M**.

( ) Alcoholism_____	( ) Colon Polyps_____	( ) High Blood Pressure___	( ) Prostate cancer
( ) Anemia_____	( ) Colon Cancer_____	( ) Iron Disease_____	( ) Seizures_____
( ) Asthma_____	( ) Diabetes_____	( ) Kidney Disease_____	( ) Thyroid Disease_____
( ) Arthritis_____	( ) Glaucoma_____	( ) Mental Illness_____	( ) Tuberculosis_____
( ) Bleed Easily_____	( ) Gout_____	( ) Migraine_____	( ) Other1:_____
( ) Breast Cancer_____	( ) Heart Disease_____	( ) Osteoporosis_____	( ) Other2:_____

Smoke? ( ) Yes: # of packs per day_____ # years_____ **Are you interested in stopping?** ( ) Yes ( ) No
( ) When did you stop smoking? _____

Alcohol? ( ) Yes ( ) No. If yes, how much? _____

Exercise Regularly? ( ) Yes ( ) No. If yes, Type & how frequently? _____

_____

(*Goal of 30 minutes of Walking-Type exercise 5 days per week is recommended)*

DELTA MEDICAL CLINIC

MEDICAL HISTORY FORM **Page 3**

DATE TODAY: _____

NAME:_____ _____
LAST FIRST M.I. Date of Birth AGE

Health Maintenance: (Interventions)

GIVE THE DATES OF THOSE PROCEDURES THAT APPLY TO YOU.

( ) Last Physical_____
( ) Ankle Brachial Index (ABI-Ultrasound Doppler)_____
( ) Audiometry (Hearing Testing)_____
( ) Automonic Nervous System Testing (ANS)_____
( ) Bone Density Scan_____
( ) Body Composition Test_____
( ) Cardiopulmonary Exercise & Metabolic Testing (CMET)_____
( ) Colonoscopy_____
( ) Continuous Glucose Monitoring Test _____
( ) D.T. (Dipthera/Tetanus) Vaccine_____
( ) ECHO _____
( ) EKG _____
( ) Flu Vaccine _____
( ) Overnight Holter Monitors_____
( ) Indirect Calorimetry _____
( ) Insomnia Study _____
( ) Lap Band Fillings _____
( ) Mammogram _____
( ) Mini Mental Status Exam _____
( ) Nerve Conduction Testing_____
( ) Pap Test_____
( ) Pneumonia Vaccine_____
( ) Sleep study_____
( ) Spirometry (Breathing test)_____
( ) Stress Test_____
( ) Tetanus, Diphtheria Toxoids and Acellular Pertussis Vaccine (Tdap)_____
( ) Tetanus and Diphtheria Toxoids Vaccine(Td)_____
( ) VNG Diagnostic Testing_____
( ) Zoster (shingles) Vaccine_____

Advance Directives

PLEASE DISCUSS WITH YOUR SPOUSE OR FAMILY AND YOU PHYSICIAN.

Living will? ( ) Yes ( ) No. **Organ donor?** ( ) Yes ( ) No.

Durable power of attorney for health care? ( ) Yes ( ) No. **Who?** _____
Last Name First Name Telephone

Review of Systems: (ROS)

To be certain that we have covered everything, during the last three months, have you had any of the following symptoms or problems? (Check **(X)** all that apply)

( ) **GEN**: Weight changes, appetite changes, unusual weakness, bleeding, fever chills, recent trauma or infections.
( ) **ENT**: Vision changes, hearing changes, nose bleeds, unusual sneezing, sore throat, swallowing difficulties, ear pain or facial pain.
( ) **NECK**: Neck pain, swellings or stiffness.
( ) **LUNGS** Cough, difficulty breathing, breathlessness on lying flat or coughing up blood.
( ) **HEART**: Palpitations or chest pain.
( ) **ABD**: Abdomen pain, nausea vomiting; vomiting of blood, diarrhea constipation, hematochezia melena acholic stools or flatulence.
( ) **GENT**: Painful urination, frequent urination, difficulty starting or stopping urination, urine urgency, urine retention, dark urine or incontinence.
( ) **BJE**: Joint pain, joint stiffness, back pain, muscle cramps or muscle aches
( ) **SKIN**: Rashes, lesions, bruising itching
( ) **NEURO**: Memory loss, disorientation, syncope, double vision, dizziness vertigo, clumsiness, funny feeling in the skin or headache

Delta Medical, P.A.
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Delta Medical Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Delta Medical, P.A. (dba Delta Medical Clinic).

I understand that diagnosis or treatment of me by Delta Medical Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Delta Medical Clinic is not required to agree to the restrictions that I may request. However, if Delta Medical Clinic agrees to a restriction that I request, the restriction is binding on Delta Medical Clinic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Delta Medical Clinic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Delta Medical Clinic's Notice of Privacy Practices prior to signing this document.

The Delta Medical Clinic 's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Delta Medical Clinic.

The Notice of Privacy Practices for Delta Medical Clinic is also provided in the waiting room and on the practice’s web site at www.delta-medical.com

This Notice of Privacy Practices also describes my rights and the duties of Delta Medical Clinic with respect to my protected health information.

Delta Medical Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by accessing the Delta Medical Clinic's web site, calling the office and requesting that a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Description of Personal Representative’s Authority

Delta Medical, PA
(dba Delta Medical Clinic)

Financial Policies & Agreement

Financial Policies and Agreement

DELTA MEDICAL PA
12001 S. Freeway Ste 210, Burleson, TX 76028
Phone: **(817) 293-8797**

Delta Medical Clinic realizes that the cost of health care is a concern for our patients. We offer the following information to help you understand our financial policy and aid you in planning for payment. Any member of our financial staff will be glad to discuss payment arrangements with you or your designated responsible party.

To help you when making decisions, our front office staff can provide you with an estimate of the charges associated with the treatment and services you are expected to receive. Please keep in mind that this is only an estimate. Actual charges may vary, depending on the treatment your physician orders for you. You are encouraged to ask us any questions relating to the services you may receive.

HEALTH INSURANCE POLICIES (FULL OR PARTIAL COVERAGE)

As a courtesy, Delta Medical Clinic will file your **primary** insurance claim for you. Therefore, at registration, you will be asked to present your health insurance card, driver's license or state ID and sign a form assigning insurance benefits to the Clinic. If your health insurance plan fails to make payment within 45 days from the billing date, you will be asked to pay the outstanding balance.

MANAGED CARE

Delta Medical Clinic has entered into contracts with various managed care organizations, including Health Maintenance Organizations (HMO), Point-Of-Service (POS) programs and Preferred Provider Organizations (PPO). Please be aware of the following prior to receiving services at Delta Medical Clinic:

1. All services rendered in this office are charged directly to you, the patient, and you are responsible for all payments, regardless of whether insured or uninsured.
2. It is your responsibility to verify that Dr. Ekadi or other provider is a participating provider in your managed care plan.
3. Some illness/condition and accompanying treatment may be declared non-covered. It is your responsibility to pay for such services at time of visit or as soon as your insurance company makes the determination not to pay.

Delta Medical Clinic will provide the necessary treatment you require. However, if your managed care plan declines to cover the services provided or pays a standard amount that is lower than the actual cost, you will be responsible for payment of any remaining balance on your account. Please refer to your insurance plan's Member Handbook for an explanation of what services may be your responsibility.

To summarize, you will be responsible for all bills, but must make immediate make payment if:

- the service is not a covered benefit
- the service is not deemed medically necessary by your insurance company
- your managed care plan requires you to pay deductibles, co-payments and/or co-insurance
- the difference between insurance company payment and amount billed if Dr. Ekadi or other providing physician is not in a contractual relationship with your insurance company
- Your insurance company declares charges are your responsibility in an Explanation of Benefits statement
- Personal checks returned due to insufficient funds will incur returned check fees, be turned over to bad checks collection third party company and may require cash payment as the only condition for settlement of bills.

YOUR DELTA MEDICAL CLINIC BILL

The notice you will receive from Delta Medical Clinic will include the fees for the actual treatment/service you received. Itemized bills are sent only upon request. If you have questions regarding this notice, please call the Billing Department at 817-293-8797. The-phone number will also appear on your notice.

PAYMENT

For all patients who must personally pay all or part of their health care bills, we accept cash, check, MasterCard, VISA and AMEX. You will be expected to pay any deductible, co-payment, coinsurance, and or any charges not covered by your insurance company. Upon receipt of a billing notice showing your balance due, you are expected to make payment **in full** or according to the terms below (if enrolled in a payment plan):

*BALANCE DUE ($)	Payments	Payment Period (Days)
50 to 100	1	*PAYMENT IN FULL WITHIN 30 DAYS*
101 to 300	3	90
301 to 600	4	120
601 to 1000	5	150
>1000		ASK TO SPEAK WITH THE MANAGER

*See Payment Plan Agreement for further information regarding payment plans.

All checks must be made out to **Delta Medical PA and mailed to PO Box 93869, Southlake TX 76092**.
To ensure timely receipt of your account information, please contact the Billing Department whenever your billing address changes.

AUTHORIZATION

I authorize **Delta Medical PA** to keep my signature on file and to charge my payments to the Credit /Debit Card, Checking or Savings Account presented. Charges may involve conversion of paper check to electronic withdrawals. Authorization to charge my credit/debit card, and or electronic ACH entries out of or into my checking/savings accounts will remain in effect until I revoke it or cease being a patient of the practice. **I hereby authorize Delta Medical PA the electronic debit or debits to my accounts as according to the terms outlined in this Financial Policies and Agreement.**

OUTSTANDING ACCOUNTS

The patient, or guarantor if the patient is a minor or dependent, is responsible for the bill and is expected to make payment arrangements if the insurance carrier does not pay it within 45 days. All accounts which remain unpaid after 90 days, will be placed in collections.

SECONDARY INSURANCE

Patients with Secondary and tertiary insurance are strongly encouraged to notify their primary insurance so that benefits can be effectively coordinated. However, each patient is responsible for making payment arrangements if balance is not coordinated with the secondary insurance. **Delta Medical Clinic does not file secondary insurance claims.** Please refer to **OUTSTANDING ACCOUNTS** above for further information.

MEDICARE WITHOUT SECONDARY INSURANCE

Medicare Patients without secondary insurance will be accepted on a case-by-case basis. Medicare patients without secondary insurance may undergo credit check, interview with the manager and sign an additional financial responsibility agreement.

MINOR CHILDREN OF SEPARATED/DIVORCED PARENTS

The parent who consents to the treatment of a minor child is responsible for payment of the services rendered. Delta Medical Clinic will not be involved with separation/divorce disputes. Please let us know if you have any questions regarding any part of our financial policy.

Thank you for choosing Delta Medical Clinic.

_____ Date _____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

Witness:_____ Date_____
(NOTE: CANNOT BE A DELTA MEDICAL PA EMPLOYEE)

CASH OR SELF-PAY PATIENTS ADDENDUM

It is our mission to provide appropriate medical care for all who require our services and to that end we welcome insured and non-insured patients. We accept **Cash, Checks, Visa, MasterCard and AMEX**. A patient is considered a self-pay or cash patient if they do not have or are not willing to present active paying insurance. In additions to applicable provisions above, all cash patients are subject to the following:

1. By signing this document, I personally accept financial responsibility for all charges incurred from receiving medical services at a Delta Medical PA facility.
2. Delta Medical PA or its providers have no financial relationship with third parties such as laboratories, imaging centers, hospitals and other Specialists. **You are financially responsible for all third party charges**.
3. Maintain **$200 deposit on account or provide a current valid Credit Card or Checking/Savings account** information at all times (**deposit or credit card requirement**).
4. Pay fully for good faith estimate of charges prior to receiving services or seeing the provider.
5. Pay additional charges or receive refund at the end of the visit if paid charges exceed or are less than initial estimate.
6. **Patient will be entitled to a refund of their $200 deposit** at the time of terminating relationship with Delta Medical PA. Such deposit will be refunded without interest within 14 days on request by the patient after all outstanding bills have been paid in full.

All cash patients are required to maintain a current credit card number or equivalent on file with us. Your signature on this form authorizes us to charge balances on your account once each month and acknowledges that you understand the entirety of this Financial Policies and Agreement document.

Please provide current Credit Card or Checking/Savings Account information and sign below.

CREDIT CARD: ❑MC ❑Visa ❑AMEX ❑Debit Card
Card #: _____

Expiration date: _____ **Security Code:** _____

_____
Print Name as it appears on the Credit Card

Credit Card Billing Address:

_____

_____

BANK ACCOUNT: ❑Savings ❑Checking

_____
Print Names as written on a Check

_____
Bank Name Bank Telephone

_____
Bank Account # **Bank Routing #**

_____
Bank Address

_____
City State Zip

AUTHORIZATION & ACKNOWLEDGEMENT

I authorize **Delta Medical PA** to keep my signature on file and to charge my payments to the credit card selected above or my Checking/Savings Account.

I authorize Delta Medical, P.A., to initiate entries to my Checking/Savings account or Credit Card. This authorization will remain in effect until I notify Delta Medial PA in writing to cancel it. I can stop payment on any scheduled charge by contacting the clinic to request cancellation of the transaction before 1PM CST on the business day prior to the day on which the payment is scheduled to occur.

I hereby authorize Delta Medical PA to initiate entries to your checking/savings account. Signing this document serves as the only notification of pending charges on my Checking/Savings Account or Credit Card. I will not receive any additional warnings, prior notifications or telephone calls from any Delta Medical PA personnel. Unavailability of funds in my account at the time of scheduled transaction will result in "insufficient fund" fees to be applied to my account with Delta Medical PA. Delta Medical PA is not responsible for any bank charges resulting from effecting this transaction.

Consultant Referrals

- Delta Medical PA providers will only refer me to appropriate *Specialist category* if the need arises as part of my medical care.
- I understand that I am solely responsible for identifying, locating and furnishing Delta Medical PA and its providers with the name(s) of *Specialists* who accept cash pay patients.

Signature: _____ **Date**_____

Delta Medical, PA

(dba Delta Medical Clinic)

Know Your Benefits

12001 South Freeway, Suite 210
Burleson, TX 76028
Telephone: (817) 293-8797 Fax: (817) 293-8793

www.delta-medical.com

PLEASE CALL YOUR INSURANCE COMPANY TODAY.

As you are probably aware, coverage under most health insurance policies HAS CHANGED. In an effort to assist our patients in understanding their insurance coverage, we have defined the following as questions that you SHOULD ASK your insurance company. These questions should be asked not only of new insurance but also of existing insurance company to determine any changes in coverage. These are only a few suggestions, so please ask any other questions you may have when you make the call.

1. What is my effective date? _____

2. If I have coverage with more than one insurance, which insurance is primary?

Which is secondary?

Which company is the primary for my child if both myself and spouse have coverage?

_____

3. Is my insurance an HMO, POS, PPO or indemnity? What does this mean?

4. Do I have out of network benefits?

5. Does my insurance require written referrals to specialists?

6. Do I have a deductible? What does that mean to me, and how much has been met?

What is the deductible for? _____

Other Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

7. Will I have co-insurance amounts due over and above my copay? ____
If yes, what are those amounts? _____

8. What is my office visit copay? _____

9. Do I have preventive/well woman coverage? _____ Is there any thing that is NOT covered?

10. How often can I have a preventive physical/well woman visit?

11. Is there copay for preventive physical/well woman visit?

12. Is there a cost limit on my preventive coverage?_____ If so, how much?

13. Is there a copay if I have labs or procedures done without seeing the physician or physician assistant?

14. Do I have coverage for screening tests? Colonoscopy, stress test, labs, mammograms, bone density testing, EKG, etc. If so, what is the rate at which these tests are covered?

15. Is there a cost limit on my preventive coverage?_____ If so, what is that limit?

16. Do I have coverage for preventive immunizations? _____

Travel immunizations?_____ Is there a co-pay when I go to the doctor for immunizations only?_____

17. What pre-existing conditions are NOT covered by my insurance?

NOTE: Medicare patients should find out when co-payments apply, especially when Medicare is offering a particular health service/exam

We will do our best to verify your coverage. However, knowing your benefit coverage **is your responsibility and will help you understand services for which you may be financially responsible.**

With so many changes that insurance companies are making, won't you please take time to learn how they will affect you and your family?