Tucker Family Medicine

NEW PATIENT REGISTRATION FORMS

Please provide the following information as accurately and completely as possible. This will become part of your office record and will be held in strict confidence.

PATIENT INFORMATION

Name (Mr./Mrs./Miss/Dr.) ____
Last name First name MI

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Widowed/Widower

Address ____

City ____________________ State __________ ZIP __________

Home phone ____________________ Mobile phone ____________________

Email Address ____

Date of birth ____________________ SS # ____________________

Employer ____________________ Work phone ____________________

INSURANCE INFORMATION

Primary Ins. Co. ____________________ Insured's Name ____________________

ID# ____________________ Group# ____________________

Secondary Ins. Co. ____________________ Insured's Name ____________________

ID# ____________________ Group# ____________________

PARTY RESPONSIBLE FOR PAYMENT/GUARANTOR

□ Check here if this information is the same as in the box above.

Name of Responsible Party / Guarantor ____

Home phone ____________________ Mobile phone ____________________

Date of birth ____________________ SS # ____________________

Primary Ins. Co. ____________________ Insured's Name ____________________

ID# ____________________ Group# ____________________

I agree to be responsible for any charges for services and materials supplied by Tucker Family Medicine and/or its Physicians/Nurse Practitioners for the patient named above.

____ ____________________
Signature of Patient, Parent, Legal Guardian or Representative Date

HIPAA PRIVACY POLICY

Patient's Acknowledgement of Receipt

Patient Name ___________________________________ Date of Birth ___________________

Tucker Family Medicine Notice of Privacy Practices provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient.

I, ____, choose to designate the individuals listed below as my primary contacts. **Tucker Family Medicine** personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

I give permission to **Tucker Family Medicine** to verbally discuss the following medical and billing information about me:

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan
- ☐ Behavioral Health information, including my symptoms, diagnosis, medication, and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medication, and treatment plan
- ☐ Lab/Test Results
- ☐ Billing and payment information

#1 Contact Name _________________________________ Relationship ___________________

Contact Phone ________________________________

#2 Contact Name _________________________________ Relationship ___________________

Contact Phone ________________________________

______ Please initial if it is appropriate to leave a detailed message with health information by voicemail, text or email.

I understand that I may cancel this permission at any time by writing Tucker Family Medicine, but that cancelling it will not affect any information that has already been released. I understand that I do not have to list anyone on this form. If so, please mark N/A on name line.

Signature ____ Date _______________________

Patient, Parent, Legal Guardian or Representative

EMERGENCY CONTACT INFORMATION

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form.

Primary Contact Name: ____

Relationship: ________________________________

Phone:
Home: _____________________ **Cell:** _______________________ **Work**: ___________________

Secondary Contact Name: ____

Relationship: ________________________________

Phone:
Home: _____________________ **Cell:** _______________________ **Work**: ___________________

____ __________________
Signature of Patient, Parent, Legal Guardian or Representative Date

CONSENT TO PHOTOGRAPH

I understand that photographs, videotapes, digital or other images may be made or recorded to document my care. I understand that **Tucker Family Medicine** will retain ownership rights to these recording or other images, but that I will be allowed to view them or obtain copies. I understand these images will be stored in a secure manner to protect my privacy and that they will be kept for the time required by law or **Tucker Family Medicine** policy. Images that identify me will be released and/or used only upon written authorization from me or my legal representative.

____ __________________
Signature of Patient, Parent, Legal Guardian or Representative Date

____
Printed Name of Patient, Parent, Legal Guardian or Representative

____
Relationship to Patient

PATIENT HISTORY

Patient Name ___________________________________ Date of Birth ___________________

Previous Primary Care Physician: ____

Last PCP Visit: ______________________ Last Blood Work: ____________________

Last Colonoscopy: ___________________ Last Mammogram: ___________________

Last Eye Exam: ______________________ Last Pap Test: _______________________

Please list other physicians and health care providers you see (specialists, therapists, counselors, chiropractors, etc.):

Provider: __________________________ Reason: ____________________________________

Provider: __________________________ Reason: ____________________________________

Provider: __________________________ Reason: ____________________________________

SOCIAL HISTORY: Do you drink alcohol? Yes / No Social / Occasionally / Light / Heavy

If so, how many per day? Beer: _________ Wine: ___________ Liquor: _____________

Current smoker? Yes / No Is so, how much per day? _______ For how long? ________

Former Smoker? Yes / No How long did you smoke? _____ How long since you quit? ______

Caffeine Use: Do you use caffeine? Yes/No How many per day? Coffee ___ Tea ___ Soda ___

Substance Use: Do you use recreational or street drugs? Yes / No

If so, what kind? _______________________ How long have you used? ____________________

FAMILY HISTORY: List any diseases that run in your family (blood relatives only)

Relative	Alive	Age now or deceased age	Diseases i.e. (cancer, heart disease, stroke, high blood pressure, diabetes)
Mother	Y/N		
Father	Y/N		
Sister	Y/N		
Brother	Y/N		
Grandmother	Y/N		
Grandfather	Y/N		

HOSPITALIZATION/SURGERIES – Date, Diagnosis and Hospital Name:

____

____

____

MEDICATION INFORMATION

Patient Name ________________________________ Date of Birth _________________

MEDICATION ALLERGIES? ____

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

Medication List – Please list **ALL** prescriptions and over-the-counter medications:

Medication (ex: Aspirin)	**Strength & Dosage** (ex: 81 mg daily)	**Reason for taking** (ex: headaches)	**Prescribing Doctor** (if applicable)

I understand that all the information that I have provided will become part of my permanent medical records and will be used as part of my medical treatment. I verify that the above information is factual and true to the best of my knowledge.

Signature: ____

Date: ____

MEDICAL INFORMATION

Patient Name ___________________________________ Date of Birth __________________

REVIEW OF MEDICAL SYSTEMS – Circle any current problems that you are having.

Change of appetite	Abdominal pain	Back Pain	Earaches	Headaches	Shortness of breath
Change of Vision	Chronic Cough	Chest Pain	Nausea	Fever	Leg Swelling
Loss of Balance	Hearing Loss	Constipation	Numbness	Dizziness	Fatigue
Loud Snoring	Heartburn	Stressed	Wheezing	Itchy/Rash	Fainting
Ringing in ears	Allergies	Joint Pain	Incontinence	Weakness	Muscle Pain
Weight Change	Bleeding	Eye Pain	Arthritis	Cough	

Additional problems not listed: ____

PAST MEDICAL HISTORY – Circle any problems you have had in the past.

Hepatitis A/B/C	Lyme Disease	Liver Disease	Thyroid Disease	COPD
Heart Disease	Diabetes	Gout	Bronchitis	Asthma
Carpal Tunnel	Blood Clots	Heart Attack	Sleep Apnea	Anemia
Cancer	Migraines	High Cholesterol	Seizures	Hernia
CHF	Parkinson	Diverticulitis	Erectile Dysfunction	

Additional problems not listed: ____

Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or any additional appointment to follow up on these concerns.

Well Visits / Preventive Care Visits & Healthcare Reform

It goes by many names: "checkup", "well visit", "annual visit", "preventive visit", but all refer to the once-a-year appointment that is dedicated to surveying your health and wellness. At this office visit we order age and health-appropriate screening tests, and plan follow-up visits for any specific problems that may be found or reported. In my practice, we use this allotted time, so we can address all the necessary preventive and wellness measures that you need at your age based on your health history.

Therefore, the well visit does not allow for simultaneous evaluation, examination and workup of problems that may be going on at the time. Problems need to be addressed as they arise in problem focused visits so that I can get a complete history of the problem, perform a detailed problem-focused exam, document it, formulate a treatment and follow- up plan for the problem, and provide any education on treatment (be it verbal or in the form of a patient handout), disease pathophysiology, and risks and benefits of medications, treatments or diagnostic tests that may be prescribed.

There has always been a slight misconception among some when it comes to what an annual well visit is. It is ok to tell us about any problems you have been having while here for your well visit, but please understand that we will probably ask you to return for a separate visit (as long as the problem is not urgent or emergent) so that we have time to evaluate and address the problem in the manner you deserve to provide the best possible health care to you. **Please note: At our discretion when additional problems are addressed we will bill the insurance accordingly and any services not covered by your insurance will be the patient's responsibility.**

Healthcare reform comes into the discussion because under the Affordable Care Act (ACA) many insurers are required to cover certain preventive services including a preventative wellness visit at no cost to you. A lot of people have interpreted that to mean that they get one doctor visit a year. Therefore, they may want to do "everything" at one visit…. prevention, counseling, screening labs, problem evaluations, maintenance medication renewals, problem medication initiation, treatment plans for one or multiple problems, procedures like freezing of skin lesions or biopsy of skin lesions, etc. This is simply not possible. It compromises your health and decreases the quality of your care. I understand that most of us have high deductible insurance plans so follow-up and problem focused visits are not covered 100% with a nominal copay like we may have been used to in the past. Don't let that lead to a compromise in your health and well-being. Bring your problems to us, but allow us the proper amount of time to address them, consider all possible diagnoses for your problem and work out the best plan for you in a visit dedicated to that problem.

Thank you for your understanding as we continue to strive to meet all your healthcare needs with the same degree of quality that you expect and have become accustomed to at **Tucker Family Medicine.**

I, the undersigned, understand and acknowledge this Policy.

____ _______________

Signature of Patient, Parent, Legal Guardian or Representative Date

____

Printed Name of Patient, Parent, Legal Guardian or Representative

FINANCIAL POLICY

Thank you for choosing **Tucker Family Medicine** as your health care provider. We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered. **Please be aware that some, and perhaps all, of the services provided may be noncovered services that are not considered reasonable and necessary by your insurance carrier.**

INSURANCE:

Participating Insurance Plans: **For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service.** To properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. **In the event your insurance coverage changes notify us immediately. If your insurance changes to a plan with which we do not participate, refer to the following paragraph.**

Nonparticipating Plans: For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill your insurance company. **Payment by cash, check or charge (Discover, VISA, MasterCard) is expected at the the time of service.**. Your policy is a contract between you and your insurance company. If you have any questions about your coverage, please contact your insurance company.

Minors: A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Claim Submission: We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply information directly to them. It is your responsibility to comply with their request in a timely manner. Texas insurance law requires your insurance company to provide timely payment. Please be aware that the balance on your claim is your responsibility to pay whether or not your insurance company has paid. We are not a party to your insurance contract.

Referrals: If you managed care plan required approval or authorization for referrals to a specialist, radiological imaging, medical facility care, etc., it is your responsibility to inform the office of this requirement prior to referral. We require 48-hour notice to facilitate a referral request and cannot issue retroactive referrals.

Self-Payment: Tucker Family Medicine recognizes that some of our patients may be without insurance coverage. We do accept self-pay patients; payment will be due the day of service.

OTHER SERVICES, CHARGES, AND PATIENT RESPOSIBILITIES: Insurance coverage generally does not include coverage for many administrative services, such as requests for information and form completion. ***The following services may have an administrate service charge that will be billed directly to you and you are responsible for payment.*** Our practice is committed to providing the highest quality of service to our patients while keeping our charges for administrative services at or below the usual and customary charges of other medical practices in our area. All such administrative fees must be paid prior to scheduling future appointments.

Missed Appointments. Broken appointments represent not only a cost to us but all an inability to provide services to others who could have been seen in the time set aside for you. **We require a 24-hour notice of cancellation to avoid a cancellation fee of $25.**

New Patient Status. Established patients who have not been seen in our office for 24 months (two years) or more will be considered "New" to the practice.

Late Arrivals. If you are more than **15 minutes** late for your appointment, you will need to reschedule for another day. Failure to keep **3** scheduled appointments without giving notice may result in you being discharged from the practice. Failure to keep **5** scheduled appointments, even with advanced notice, will result in you being discharged from the practice.

Form Completion. All forms requiring medical review and a Physician's signature including school, day care, & camp physicals, prior authorizations, FMLA, disability or other paperwork will require the patient to schedule an appointment to be seen by the practitioner and may be subject to an administrative fee of $25.

Requests for Medical Records. **Tucker Family Medicine** requires written requests for the release of medical records. The administrative fee associated with copying medical records is based on current Texas law. Please take this into consideration when requesting copies of your medical records and allow 5 – 7 working days for processing the request.

Medication Refills Requests. Please allow up to 72-hours to process prescription refill requests. Our staff cannot accommodate last minute requests for refills. For quicker processing, call your pharmacy directly.

Delinquent Accounts. Statements will be mailed for outstanding balances. If more than one statement is mailed in an attempt to collect an outstanding debt an administrative fee may be assessed. Delinquent fees will be submitted to an outside collection agency. If your account is transferred out of our office for collection, you will be responsible for all fees incurred by **Tucker Family Medicine** to collect your outstanding debt.

Returned Checks. Returned checks will incur a fee of $35. If more than one check is returned on your account, we will require all future payments be made by cash, cashier's check or credit card. Any checks that are not paid will be filed with the District Attorney's office for collection. All fees incurred in the filing will be your responsibility.

Authorization to Pay Benefits to Physician/Clinic and Assignment of Benefits:

I hereby assign payment directly to **Tucker Family Medicine** for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance.

Authorization to Release Information:

I hereby authorize **Tucker Family Medicine** to release any information acquired during my examination or treatment to my referring physician and/or my insurance company.

Acknowledgement:

I have read and understand the above **Financial Policy and Benefit Authorization** and agree to all provisions outlined herein.

____ __________________

Signature of Patient, Parent, Legal Guardian or Representative Date

MEDICAL RECORDS RELEASE

Kindrell S. Tucker, M.D. Linda C. Robbins, R.N., A/GNP

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name ____ **Date of Birth** ___________

Address ____
Street **City** **State** **ZIP**

Please transfer my medical records* as follows:

From: ________________________________
____
____

To: **Tucker Family Medicine**
1320 S John Redditt Dr. Ste B
Lufkin, TX 75904
Phone: 936-225-3657
Fax: 936-899-7293

***Records to be released**:
__ Annual Exam and PAP / Prostate Exam
__ Labs/X-ray
__ Consult Notes
__ All Medical Records
__ Other ____________________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STI test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

____ ____________________
Signature of Patient, Parent, Legal Guardian or Representative Date

____ ____________________
Witness Date