Acceptance of Liability Waiver/Insurance Filing
Informed Consent

There are many health insurance plans available to employers and individuals. All plans are not equal. There can be significant variance on services covered, deductibles, co-pay requirements, network requirements, pre-authorization for services, and other requirements of the policy. **It is the insured's responsibility to verify that the services requested and the physicians are covered by the terms of your insurance plan.** If there are any questions the insured is to call his/her insurance carrier to confirm coverage.

We will bill the insurance carrier on the patient's behalf. If any services are denied as out of network, not covered by the terms of the policy, policy not in force, not medically necessary, or deductible/co-pay issues, the patient or responsible party will be billed.

I have been advised of the billing protocol of Lake Arlington Family Medicine. I recognize and accept responsibility for payment should the services provided by my physician be excluded or not covered by my insurance plan.

Patient Signature Date

The information requested on this form is necessary to comply with Federal Regulations, to properly establish the medical record, and filing insurance claims. It is important that all information is complete. Thank you.

- -

Patient Last Name First MI Social Security Number

/ / M F M S D W Other Full Part Not a Student Full Part Self Ret Military Other

Date of Birth **Sex** **Marital Status** **Student Status** (circle one) **Employment**

Mailing Address City State Zip

Primary Phone Secondary Phone Email

How did you hear about Lake Arlington Family Medicine?
Drive-by/Sign Family/Friend Insurance Provider Other: _____.

Authorization to Release Information
I authorize Lake Arlington Family Medicine to release all medical information necessary to process claims for payment of services provided by The Physician's Clinic, PA.

Patient Signature Date

Assignment of Benefits
I assign and authorize payment of all medical benefits, commercial insurance, workers comp, and government agencies directly to Lake Arlington Family Medicine.

Patient Signature Date

Medical History

Name: _____ DOB:_____

Pharmacy with address: _____

Preferred **lab** company:
(circle) Quest - Labcorp - Clinical Pathology Laboratory(cash pay lab) - Other: _____

Allergies: _____

Hospitalizations/surgeries/ER visits **AND** approximate dates:_____

_____

Family Medical History:_____

_____

Preventive Care (Last Physical/Stress Test/Colonoscopy, etc.) _____

_____

Social History (Alcohol/Drugs?): _____ Smoking?(cigarettes or E-cigs):_____

Medical Issues and Diagnosis Date (example: Hypertension 04/2018, Diabetes, High Cholesterol, Stroke, Cancers, etc.)

_____

_____

_____

WOMEN ONLY: Last pap smear: _____ Last mammogram: _____

Medication List

Name Dosage Frequency

_____

_____

_____

_____

_____

_____

_____

Missed Appointments and Late Arrivals Policy

The physicians and staff of Lake Arlington Family Medicine make significant effort to assure that we respect our patient's time and maintain a reasonable appointment schedule. We avoid overbooking of patient appointments and schedule the appropriate amount of time to manage the patient's designated condition.

Because we do limit the number of appointments, it is important that all patients commit to keeping their appointments as scheduled. A missed appointment may prevent a sick patient from obtaining immediate care.

The following guidelines apply equally to telephone/Telehealth/Virtual Visits.

All patients that are unable to maintain a scheduled appointment are instructed to call Lake Arlington Family Medicine 24 hours in advance to reschedule or cancel the appointment. Failure to notify the physicians office within the 24 hour period will result in a NO SHOW fee of $50. This fee will not be billed to the insurance carrier and is the patient's responsibility.

Patients that miss three or more appointments without notice will be subject to termination from the practice. This applies to the patient's entire household.

Patients that arrive 15 minutes or more past their scheduled appointment time may be required to reschedule their appointment or may be seen as a work in appointment. Patients that have arrived as scheduled will be seen with priority. If the schedule is full and conditions do not allow for work ins, the late arrival may be asked to reschedule to a different date.

We do appreciate your assistance in maintaining an accurate appointment schedule and will continue to do our best to honor your time.

I have read, understand and agree to this Missed Appointments and Late Arrivals Policy.

Patient/Representative Signature Date

Printed Patient/Representative Name

Acknowledgement of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

Furthermore, by my specific **initials**, I authorize my physician and his/her staff, to contact me by the designated means below:

_____Home Phone
_____Home Answering Machine/Voice Mail
_____Office/Work Place, Voice Mail
_____Cell Phone/Voice Mail
_____Email

Additionally, by my **initials,** I authorize my physician and his/her staff, to communicate information regarding appointments, medical results, and billing issues to:

Initials	Name	Phone	Relationship

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Controlled Substances Treatment Agreement

Controlled substances/controlled medications are used to treat a variety of medical problems, including ADHD, Anxiety, Insomnia, Pain, etc. Along with these treatments, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic medication, psychological counseling or other therapies or treatment.

By my signature below, I understand that compliance with the following guidelines is important in continuing treatment with Lake Arlington Family Medicine. I understand that I have the following responsibilities and agree to adhere to all of the following rules while I am under the care of Lake Arlington Family Medicine.:

1. I will take medications as prescribed.
2. I will not increase or decrease the dose without the approval of my physician/APRN.
3. I will not obtain these medications from several physicians, but my physician/APRN only.
4. I will not share the medication with anyone including family members.
5. I will not sell the medication.
6. I will not get a replacement from any lost or stolen medication regardless of the circumstance.
7. I will not get early refills.
8. I will notify Lake Arlington Family Medicine if I abuse alcohol or use other illicit drugs along with prescribed medications.
9. I understand I can only receive medication refills at scheduled appointments.
10. I will not request prescription refills when the clinic is closed after hours or on weekends.
11. I will agree to an initial in person appointment by each physician/APRN as required by the state prior to being prescribed controlled medications.
12. I agree to schedule an appointment/telehealth visit no longer than every three months for the purpose of renewing my prescription and assessing my progress.
13. I will not request a controlled medication refill prior to the required lab draw and lab result review with provider.
14. If I am pregnant or intend to get pregnant, I am required to notify Lake Arlington Family Medicine immediately to discuss discontinuing medications that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.

I understand that the physician/APRN may stop prescribing the medication or change the treatment plan if I fail to follow the above recommendations. I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of controlled substances/controlled medications for my treatment.

_____ _____

Patient Name Patient Signature Date

Lake Arlington Family Medicine, PA (LAFM) participates in Medicare and most commercial insurance plans offered nationally and specifically in the North Texas Market. We do our best to ensure that all of our services are covered by the patient's plan, but some services listed below may not be covered by your insurance policy.

Listed below are the few services that a patient's plan may not cover. If the patient's insurance does not cover services, the patient will be responsible for the full fee.

It is the patient's responsibility to verify their insurance coverage for any of the procedures listed below.

Weight Loss: Most insurance carriers now cover weight loss when the patient's BMI is over 30. We do recommend the patient call their insurance carrier to confirm that the provider's services, laboratory services, and prescription medications are covered.

_____ _____

Patient Signature Date

Vitamin B 12 Injection: Vitamin B12 Injection coverage is generally limited to a single diagnosis of Precious Anemia or specific digestive disorders. If a B12 injection is requested, the patient is to pay the fee at the time of service.

_____ _____

Patient Signature Date

Pre-Operative Clearance, *Cosmetic or Bariatric Surgery:* Most insurance carriers do cover pre-operative clearance exams without difficulty. However, if the procedure is designated Cosmetic, most insurance carriers will not cover the pre-operative clearance. Patients that are having Cosmetic procedures will be required to pay the pre-operative clearance fee at the time of service.

Other pre-operative clearance evaluations may be subject to a deductible or coinsurance fee. Pre-Operative clearance for Cosmetic procedures are to be paid at time of the visit.

_____ _____

Patient Signature Date

Auto Accident: LAFM does not participate as a provider for any auto accident management. The patient will be required to pay for medical care at the time of service. As a courtesy, LAFM will provide the patient with an itemized claim form, by mail, for the auto-related encounter. The patient is to submit the insurance claim to the appropriate auto carrier for reimbursement.

_____ _____

Patient Signature Date

Limited Benefit Plan (LBP) Insurance: LAFM does not participate in any LBP insurance plans. These plans are very limited in coverage and may or may not cover sickness or preventative care. If you are participating in an LBP plan, the patient's responsibility is to contact the insurance carrier to confirm what services are covered. Patients in LBP's are required to pay at the time of service.

_____ _____

Patient Signature Date

Updated No Show Policy

Due to an increase in no shows in the office, **the no show fee is now $50**. This fee will not be billed to the insurance carrier and is the patient's responsibility.

_____ _____

Patient Signature Date