SPECIALTYCARE CLINICS

Julli Randol NP-C
6101 Windhaven Pkwy Unit # 145 Plano, Tx 75093
Phone: 972-473-8980 Fax: 972-212-6851

PATIENT INFORMATION

Patient Name: _____ DOB: ____/____/_____ Sex: ❑ Male ❑ Female
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
SS: _____-_____-_____ Drivers License: _____
Home Phone: _____ Cell phone: _____
Email: _____
Emergency Contact: _____
Relationship: _____ Phone: _____

Are your medical expenses handled by an attorney? ❑ Yes ❑ No
If yes, name: _____ Phone: _____

REFERRAL INFORMATION:

Did a Doctor refer you? ❑ Yes ❑ No
Referring Doctor Name: _____
Primary Care Physician: _____
Phone: _____ City: _____

PHARMACY INFORMATION:

Pharmacy Name: _____ Phone: _____
Address: _____
❑ No Pharmacy History

INSURANCE INFORMATION (if applicable, provide a copy of your insurance card:

Insurance Company: _____
Phone: _____
Name on Card: _____
Relationship to Cardholder: ❑ Parent ❑ Spouse ❑ Self
Member ID: _____ Group #: _____

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Social History:

❑ Employed (occupation) _____
❑ Student ❑ Retired ❑ Other: _____
Relationship Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Children? ❑ Y ❑ N If so, ages: _____
Live alone? ❑ Y ❑ N If yes, do you have help or family nearby? _____
Smoker? ❑ Y ❑ N If so, packs per day: _____ For how long: _____
Quit Smoking: Within past year: ❑ 2 to 4 years: ❑ 5 to 10 years: ❑
Chew Tobacco: ❑ Y ❑ N If so, how much: _____ For how long: _____
Drink Alcohol: ❑ Y ❑ N Daily: ❑ 1-2x/week: ❑ 1-2x/month: ❑ 1-2x/year: ❑
Drugs (Marijuana, Cocaine, etc) ❑ Y ❑ N If yes, what: _____

Medications: Please list all medications you currently take with doses and schedule:

Current Medication	Dose/Schedule	Reason for Medication

Allergies to medications:

_____
_____
_____
_____

Family History:

Member	Alive	Deceased	Age	Health Status/Cause of Death
Father	❑	❑	_____	_____
Mother	❑	❑	_____	_____
Sister/Brother	❑	❑	_____	_____
Sister/Brother	❑	❑	_____	_____
Sister/Brother	❑	❑	_____	_____
Sister/Brother	❑	❑	_____	_____

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Patient Name: _____ **DOB:** ____/____/_____

Reason for Visit: _____

Patient Medical History:

- ☐ Abdominal pain
- ☐ Anemia
- ☐ balance problems
- ☐ bleeding problems
- ☐ blood clots
- ☐ bloody stools
- ☐ Urine with blood
- ☐ Chest pain/angina
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eating disorders
- ☐ Female organs / Menstrual
- ☐ Fever
- ☐ Hypertension
- ☐ Muscle spasms
- ☐ Nausea
- ☐ Osteoarthritis
- ☐ Convulsive epilepsy
- ☐ Difficulty breathing
- ☐ Sleep apnea
- ☐ speech changes
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Swelling
- ☐ Inflamed glands
- ☐ Thyroid disease
- ☐ Shaking
- ☐ Urinary retention
- ☐ Vision changes
- ☐ Weight Loss
- ☐ Other / Not listed

Females:

Last menstrual cycle: _____
Are you on any birth control? ❑ Yes ❑ No
If yes, what birth control are you on? _____ Pregnant: ❑ Yes ❑ No
Are you currently breastfeeding? ❑ Yes ❑ No

Past Surgical History:

Surgeries	Year	Facility	Phone	Complications

Have you ever had problems with anesthesia? ❑ Y ❑ N
Describe: _____

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CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

PATIENT NAME: _____ **DOB:**____/____/_____

CONSENT FOR TREATMENT

I authorize IMED Physicians, to examine me (or the patient I am legally responsible for) and to do any x-rays or other diagnostic tests that may be needed to make a diagnosis and to provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits, and risks.

FINANCIAL AGREEMENT

I agree to pay all professional fees charged by Specialty Care Clinics for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if Specialty Care Clinics has agreed to accept insurance benefits as full payment for covered services in accordance with federal or state law (e.g. Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such Insurance benefits are paid within 60 days of claims submission, and provided there is no recovery from a third-party negligence lawsuit (see Injuries and Third-Party Negligence, below). Ultimately, it is my responsibility to understand the coverage that I pay for in a monthly premium to my carrier. If an employer or its carrier denies a claim for payment for a work-related injury, or if a prepaid health plan, managed-care health plan, or Medicare, considers certain services ineligible or uncovered services, then I (patient) agree to pay for those services. It is understood that claims for services remaining unpaid 60 days after claims submission shall be presumed ineligible for insurance reimbursement, and I (patient) shall pay for those services. If the patient is a minor — the parent/guardian who requests treatment for a child will be responsible for all fees.

INJURIES AND THIRD-PARTY NEGLIGENCE

I understand and agree that if Specialty Care Clinics has granted discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award, or settlement of any lawsuit arising from treated injuries or illness, then I shall give a lien to Specialty Care Clinics against such monetary recovery in the full amount of such discounts.

DELINQUENCY

If my (the patient's) account becomes delinquent, I understand that Specialty Care Clinics at its sole discretion, may refer to a collection agency or an attorney as allowed by law.

INSURANCE ASSIGNMENT

I authorize my insurance company or third-party payer to whom a claim for payment has been submitted to pay any eligible benefits directly to Specialty Care Clinics. I hereby authorize payment to go directly to Specialty Care Clinics for medical benefits payable by my insurance company (and/or Medicare) and understand that I am responsible for any charge not covered by the terms of my insurance policy. I hereby assign Specialty Care Clinics full rights to represent my (the patient's) interests in any complaints of appeals for denial of benefits or reimbursement to the Texas Department of Insurance (State Insurance Commissioner). I hereby authorize said assignee Specialty Care Clinics to furnish these agencies such information as may be necessary to support such complaints or appeals.

I agree I cannot revoke the FINANCIAL AGREEMENT or INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid. I have read, understand, and do hereby agree to the terms of the foregoing Assignments, Authorizations, and Releases. I also certify that the PATIENT INFORMATION I have provided is true and accurate, to the best of my (the patient's) knowledge.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** ____/____/_____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ❑ Yes ❑ No

May we leave a message on your answering machine at home or on your cell phone? ❑ Yes ❑ No

May we discuss your medical condition with any member of your family? ❑ Yes ❑ No

If YES. please name the members allowed:

_____

This consent was signed by: _____ (Print Name Please)

Signature: _____ DATE: ___/___/____

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INSURANCE POLICY, PRESCRIPTION REFILLS PROTOCOL AND APPOINTMENT CANCELLATIONS

PATIENT INSURANCE POLICY:

- It is your responsibility to know your insurance and bring your card with you to all appointments.
- Is **Julli Randol NP-C** a CONTRACTED PROVIDER of your insurance?
- Do you need PRIOR AUTHORIZATION for procedures?
- Are X-Rays and Supplies included in your COPAY?
- How much is your COPAY for a Specialist?
- Do you have a YEARLY DEDUCTIBLE? If so, has it been met?

PLEASE HELP US HELP YOU. There are hundreds of insurance companies thereby making it almost impossible for our staff to know the specific requirements for each policy. Please call your insurance company prior to your appointment to obtain this needed information.

PROTOCOL FOR PRESCRIPTION REFILLS:

- Please allow 48-72 hours on refill requests
- Call your pharmacy first and request a refill to expedite your request

In order to be as efficient as possible, these are the policies in effect regarding all prescriptions.

I have read and understand the above information regarding MY INSURANCE POLICY and PRESCRIPTION REFILLS.

CANCELLATION AND NO SHOW POLICY $25 NO SHOW FEE

We understand that situations arise in which you must cancel your appointment. If you must cancel your appointment, please provide at least 24-hour advance notice. This will enable another patient who is waiting for an appointment to be scheduled.

Office appointments which are canceled with at least 24-hour notification do not receive penalties. The No Show fees are the sole responsibility of the patient and must be PAID IN FULL BEFORE BEING RESCHEDULED for your appointment. After THREE consecutive no show to appointments, you will be discharged from the practice for non-compliance.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** ___/___/____

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MEDICAL RELEASE FORM

I hereby authorize _____ to release to Specialty Care Clinics located at
6101 Windhaven Pkwy Unit # 145 Plano,Tx 75093
Phone: 972-473-8980 Fax: 972-212-6851

Information contained in the Medical Records of:

Name of Patient:_____
Date of Birth:_____
Address:_____

Specific information to be disclosed includes: patient medical history, physical therapy reports, operative reports, imaging (x-ray/MRI/CT scan), lab reports, chart notes, immunization records, and psychological reports.

THIS INFORMATION IS PRIVILEGED, CONFIDENTIAL AND DISCLOSED FOR THESE PURPOSES ONLY: HEALTHCARE MANAGEMENT; WORKER'S COMPENSATION AND PERSONAL INJURY CASE MANAGEMENT; HEALTHCARE INSURANCE PROCESSES (REFERRALS, PRIOR AUTHORIZATIONS, ETC).

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it; and that in any event, this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event, or condition as follows. I agree that a photocopy of this authorization may be considered valid.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** ___/___/____