LAKEWOOD
FAMILY HEALTH

PATIENT INFORMATION				❑ ***New Patient*** ❑ ***Established PT***
Patient's FIRST Name: MIDDLE: LAST:				Social Security #:
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:
Your Address:		City	State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other		Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_____
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )		Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No
Referring Physician Name:		How did you hear about our office?		
Primary Physician Name:		Reason for visit:		Date of Inj/Onset:

RESPONSIBLE PARTY:		
Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:	Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):	Birth date: / /	Social Security #:

INSURANCE INFORMATION:			
Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑ 80/20 ❑ 90/10 ❑ 70/10 ❑ Don't Know	Effective Date: / /
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:	
Claims Address:			Phone#: ( )
Policy#:	Group #:	Group Name:	
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:		

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to XXXX as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: Date

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Financial Policy

Patient Name: _____ DOB: _____

Effective Jan 1, 2016

Thank you for choosing Lakewood Family Health as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Lakewood Family Health will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Lakewood Family Health. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Lakewood Family Health at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ Lakewood Family Health will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Lakewood Family Health if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party: _____ Date: _____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Lakewood Family Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ Date: _____

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PATIENT PRIVACY ACKNOWLEDGEMENT AND GENERAL CONSENT

Patient Name: **DOB:**

I wish to be contacted regarding appointments, tests and test results, diagnoses, treatments, and billing in the following manner: (Please Circle)

HOME PHONE / VOICEMAIL	**YES**	**NO**	**N/A**
Leave detailed message			
Leave message with callback number only			
WORK PHONE / VOICEMAIL	**YES**	**NO**	**N/A**
Leave detailed message			
Leave message with callback number only			

I hereby give permission to the staff of LWHP Family Wellness Group, PPLC dba Lakewood Family Health to disclose and discuss any information related to my medical condition, to include appointments, tests and test results, diagnoses, treatments, billing to / with the following family member(s).

Name	DOB	Relationship	Phone Number
Name	DOB	Relationship	Phone Number

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. I acknowledge that the information I have provided above is true and correct. In addition I acknowledge by my signature below that I have received a copy of the "Notice of Privacy Practices" which is in this packet. LWHP Family Wellness Group, PPLC dba Lakewood Family Health reserves the right to change our privacy policy. I may at any time request a copy of the privacy policy.

GENERAL CONSENTS

_____ AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the LWHP Family Wellness Group, PPLC dba Lakewood Family Health Patient Information Privacy Policy. I hereby authorize _____ or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

_____ AUTHORIZATION TO MAIL, CALL, OR E-MAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a LWHP Family Wellness Group, PPLC dba Lakewood Family Health representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying the LWHP Family Wellness Group, PPLC dba Lakewood Family Health to that effect in writing.

_____ LAB / X-RAY / DIAGNOSTIC SERVICES:

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, X-Ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff. I understand that I may receive a separate bill for these services.

_____ CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by my LWHP Family Wellness Group, PPLC dba Lakewood Family Health Provider or his / her designee.

Signature **Printed Name** **Date**

Relationship if Patient Representative **Physician Office Representative**

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DISCLOSURE REGARDING ANCILLARY SERVICES / RESEARCH PROGRAMS

Ancillary Services

Your provider may refer you to one or more ancillary Services in connection with your medical care. An "ancillary service" is a service that is provided by a third party relating to your medical care or treatment. The following types of services are ancillary services:

- Magnetic Resonance Imaging (MRI)
- Bone Density Imaging
- Mammography
- Nuclear Lab
- Ultrasound
- Laboratory
- Computer Tomography (CT)
- Angiography
- Vascular Laboratory
- Echo
- Position Emission Tomography
- Sleep Therapy
- X-Ray

In addition, providing Durable Medical Equipment (such as wheel chairs) and Infusion Drug Services are ancillary services.

Your provider may have an economic interest in or other business relationship with the company or other person to whom the provider refers you to obtain an ancillary service. You are not obligated to use the person to whom your provider refers you for an ancillary service. You are free to use any person you choose to provide you with an ancillary service.

Research Programs

Your provider may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. Your provider may be compensated for services rendered in connection with the research program or another research program. You are not obligated to participate in any research program and we will obtain your permission prior to your participating in a program your provider believes may be appropriate for you.

Please feel free to ask your provider if you have any questions about a particular ancillary service or research program.

_____ _____

Patient Signature Date

_____

Printed Name

LAKEWOOD
FAMILY HEALTH
6331 Prospect Ave, Dallas Texas 75214
214-821-6331

HIPAA 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 READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

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Your Rights

Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your physician is not required to agree to a restriction that you may request. If physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your physician amend your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints – You may complain to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on January 1, 2016.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____Signature_____Date_____