Graham Healthcare

Urgent Care

PATIENT INFORMATION				
First Name:	Middle Name:	Last Name:	Date of Birth:	Social Security #
Mailing Address:	City:	State:	Zip Code:	
E-Mail Address:	Home Phone #	Cell Phone #		
Gender: ☐**M** ☐**F**	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated			
Employer:	Occupation:	Employer Phone #		
Emergency Contact:	Relation:	Contact Phone #		

Have you seen Dr. Purdy or Dr. Johnson at any of the following locations in the last 3 years?

☐Olney Family Clinic ☐Olney Hamilton Hospital ☐Archer City Family Clinic

For appointment reminders and other communication purposes: (REQUIRED)

Do you wish to receive text messages? ☐**Yes** ☐**No**

Do you wish to receive automated phone calls? ☐**Yes** ☐**No**

RESPONSIBLE PARTY INFORMATION			
Name:	Relation:	Date of Birth:	Social Security #
Mailing Address:	City:	State:	Zip Code:

INSURANCE INFORMATION		
Insurance Company:	Member ID #	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's SSN:	Patient's Relation to Policy Holder:

Signature **Date**

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Review of Privacy Practices & Consents

Acknowledgement of Review of Notices of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. We are permitted to use and disclose your medical information to those involved in your treatment. We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. We are permitted to use and disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization. The following are situations where we may disclose your medical information without your authorization: Public Health, Abuse or Neglect, Legal Proceedings, Law Enforcement Research, Organ Donation, Coroners, Medical Examiners, Funeral Directors, and any other instances required by law. HIPAA provides several privileges that patients may exercise intended to protect patient privacy. Those rights are as follows:

1. You may request that we restrict how your protected medical information is used. We, however, do not need to agree to this restriction.
2. You may request that we send your protected health information by alternative means or to an alternative location.
3. You may inspect and/or copy your health information within a designated record set; request must be in writing. There are limitations regarding the information you may inspect or copy. Texas law requires us to release this information within 15 days of your written request received by our office. We will inform you if access has been denied or limited. HIPAA permits us to charge a reasonable cost-based fee for such information.
4. You may request an amendment of your medical information, however, we are not required to do so.
5. You may request an accounting of certain disclosures that are for means other than for treatment, payment, health care operations, or made via an authorization signed by your or your representative.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. If you are concerned that your privacy rights have been violated, you may contact the Privacy Officer at (940) 282-2513. In addition, if you feel your complaint hasn't been resolved internally by our office then you also have the right to file a civil rights or health information privacy complaint by emailing OCRMail@hhs.gov or by calling (800) 368-1019.

Consent for Treatment

By signing this form, I consent to the treatment and care provided by Graham Healthcare and Urgent Care (GHCUC) and its associated physicians, nurses, and other clinical providers. I am aware that the practice of medicine and other health care professions is not an exact science and that no guarantee has been or can be made regarding the results of the treatments. I am consenting to any exams, X-rays, laboratory procedures, tests, medications, medical treatment, pictures, videos, and other services determined advisable for the patient by the attending doctors or other healthcare providers. Other healthcare providers could include other treating or consulting providers, their associates, technical assistants, nurses, and other clinical staff.

Prescription History Consent

By signing this form, I voluntarily consent to provide GHCUC and its affiliated provider's access to and use of my prescription medication history from other healthcare providers, insurance companies, or third party pharmacy benefit payers for treatment purposes. This information will become part of your medical record.

I further acknowledge that GHCUC and its affiliates may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand that this Prescription History Consent will be valid and remain in effect as long as I attend or receive services from GHCUC, unless revoked by me in writing with such written notice provided to each practice site I attend and/or physician from which I receive my services.

Payment Policy

Graham Healthcare and Urgent Care strives to be your premier healthcare provider. Our payment policy helps us keep our doors open and to be fair to all of our patients. GHCUC accepts payment and most insurances. If any patient is owed a refund, all claims must be processed and paid in full before overpayment is refunded.

Insurance: GHCUC will file your insurance for services provided at your visit. All managed care co-payments are due at the time of service. Your insurance policy is a contract between you and your insurance company. It is important that you understand your coverage. We cannot guarantee payment of your claims. We will attempt to verify coverage, but that is not a guarantee of payment until your insurance has processed the claim. Per your insurance company guidelines, you may be responsible for any unpaid balance. If your insurance denies payment, you will assume full responsibility of the charges incurred for that visit.

HMO/EPO/POS: If your plan requires a Primary Care Physician (PCP) assignment, you agree to obtain all referrals necessary for you to be seen. You can designate one of our Providers to be your PCP however the assignment must be effective the day of your appointments. All payments deemed by your insurance will be due at the time of service. No exceptions will be made.

Medicare: GHCUC accepts assignment and will file insurance for our Medicare patients. We will also file secondary insurance after payment from Medicare. If there is no secondary insurance, the patient will be billed for any remaining balance.

Medicaid/CHIP: I understand that the amount owed to GHCUC for covered services will be satisfied by amounts paid by Medicaid/CHIP for such services and that I will not be billed by GHCUC for services covered by Medicaid/CHIP. I further understand that the services or items that I request to be provided to me may not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my/my child's care. I understand that the Texas Health and Human Services Commission or its health insuring agent determines the medical necessity of the services of items that are received. I also understand and agree to change my/my child's PCP to GHCUC's supervising physician on the day of service if I have CHIP, Superior, or Amerigroup Medicaid.

Cancel/No-Show: Excessive no shows and/or late cancellations could be grounds for termination from GHCUC.

Returned Checks: Any returned check will result in a $30 returned check fee. After receiving a returned check, we will no longer accept check payments on any future visits not to exceed five years.

Collections: For all account balances in excess of 90 days past due, the account will be turned over to our collection agency if payment is not received in 15 days. It is ultimately the patient's responsibility to make sure the doctor received payment for services rendered.

I have read, understand and agree to the above Financial responsibilities statement, Payment guidelines, consent for treatment, and release of any and all medical information and insurance authorization. I also certify that all information provided as complete and accurate to the best of my knowledge.

Patient's Printed Name	**Date**
Signature of Patient or Authorized Representative	**Relationship to Patient**
Witness	Date

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Authorization Form for Release of Protected Health Information

By signing this form, I authorize you to disclose protected health information below by telephone, fax or mail.

Patient Name _____ **Date of Birth** _____

Released to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The information you may release subject to the authorization is as follow:

Check All that Apply:

___ **All Health Information (By checking this box you do not need to check any other box)**

___ Appointments date/time	___ Explanation of diagnosis	___ Physician's Orders
___ Explanation of procedure	___ Pathology Reports	___ History/Physical Exam
___ Billing Information	___ Patient Allergies	___ Past/Present Medications
___ Lab Results	___ EKG Reports	___ Radiology Reports/Images

___ Other: _____

This authorization is valid for until the following even and/or date:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the practice: 1005 Highway 16 S, Graham, TX 76450

I understand that prior actions taken before the revocation of authorization to access my health information will not be affected.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the receipt and may no longer be protected by Federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Authorized Representative _____ **Date** _____

Vascular Screening

Patient Name: _____ **DOB:** _____ **Phone:** _____

Indications for Arterial Screen (Quantaflo)

Please check all that apply

_____ Past or Current Smoker
_____ Diabetes
_____ History of Stroke
_____ History of a Heart Attack
_____ History of Leg Ulcer
_____ Pain in Legs is Worse with Walking
_____ Lower Leg Skin Discoloration

- Quantaflo check and Ultrasound should be performed if any of the above apply.

Indications for Venous Screening/Diagnostic (Venous Ultrasound)

Please check all that apply

_____ Varicose/Spider Veins in the Legs
_____ Pain/Aching in the Legs
_____ Leg Heaviness or Tiredness
_____ Leg Itching, Burning, or Throbbing
_____ Swollen Legs or Ankles
_____ Leg Cramps or Restless Legs

- Venous Ultrasound should be performed if any of the above apply.

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625 Dallas Dr Suite #400, Denton, TX, 76205; Ph. (817) 668-1360 : Fax (817) 402-0089