Family Care Clinic of PANHANDLE

NAME_____DOB_____AGE_____Social Security_____
Mailing Address_____
Home Phone:_____Cell Phone:_____
Male_____Female_____Single_____Married_____Divorced_____Widowed_____
Name of Spouse:_____Name of Employer_____
Emergency Contact Name/Number:_____
Person responsible for the bill Name:_____Social Security_____
DOB_____Mailing Address_____
Home Phone:_____Cell Phone:_____

Insurance_____
Insured Name_____
DOB_____
Social Security_____
Policy Number_____
Group Number_____

Insurance_____
Insured Name_____
DOB_____
Social Security_____
Policy Number_____
Group Number_____

When registering, please present insurance card and driver's license. Payment is expected at the time of service.

Authorization to Release Information

Panhandle Family Care, LLC may disclose all or part of this patient's records to any insurance company or association, or the Federal or State Government, as such information may be necessary for the completion of all clinic claims. I understand that the information to be released may include information pertaining to mental or psychiatric-related conditions and/or drug or alcohol abuse. A copy shall be as valid as the original.

Assignment of Benefits

I hereby authorize payment to Panhandle Family Care, LLC benefits specified herein and otherwise payable to me for any services rendered by the clinic subsequent to this date and for other such charges as may be made by aid clinic. I hereby agree to pay the same and also agree that in the event medical coverage is sufficient, to pay the indebtedness incurred. Should there be any money over and above that necessary to pay this registration, I agree that said clinic may apply coverage against any amount which is owed (by me, my spouse, or legal dependents of mine or spouse at the time to Panhandle Family Care, LLC.

I certify that the information given by me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or any related medical claim. I request that payment of Authorized Benefits be made on or in my behalf to Panhandle Family Care, LLC. A copy shall be as valid as the original.

Name:_____ Witness:_____

Signature:_____ Date:_____

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Patient Questionnaire

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and healthcare operations):

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

III. Please print the address of where you would like your billing statements and/or other correspondence from our office be sent:

_____

_____

IV. Please print the daytime phone numbers where you would like to receive communications regarding your appointments, lab and x-ray results, and other healthcare information: (____)_____ (____)_____

"I am fully aware that a cellular phone is not a secure and private line."

V. Can confidential messages (ie, appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME_____

PATIENT/GUARDIAN SIGNATURE_____

DATE:_____

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Referral / PCP Policy

- If you have an insurance policy that requires a PCP selection, it must be a physician in this facility. **If we are not your PCP** you will be considered a self pay patient. We will also be unable to submit any referrals on your behalf.
- If you have an appointment with a specialist you will **have to have** a referral from your primary care physician. If we have not seen you for the specific diagnosis, you will be required to schedule an office visit at this facility for a coordination of care.
- **We will require 5-7 days to complete all referrals.** You will need to schedule your visits accordingly, and make sure to contact our office with the information as soon as possible.

_____ _____

Signature Date

_____ _____

Witness Date

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Receipt of Notice of Privacy Practices

I, _____, hereby acknowledge receipt of Panhandle Family Care, LLC Notice of Privacy Practices. The notice of Privacy Practice provides detailed information about how Panhandle Family Care, LLC may use and disclose my confidential information.

I understand that Panhandle Family Care, LLC reserves the right to change their privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Signature Date

If you are not the patient, please specify your relationship to the patient:

_____

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The providers and staff at Panhandle Family Care, LCC feel that we can better serve your healthcare needs if you are familiar with the following policies and procedures of the group:

Office Hours:

Panhandle Family Care is opened Monday through Friday from 8:00 am to 6:00 pm. These hours are subject to change according to need.

Appointments:

Appointments may be made by calling (806) 532-2273 during our office hours. Every effort will be made to provide the earlies possible attention for the convenience of the patient. Due to the unscheduled nature of emergencies imposed upon the providers, occasional delays do occur. We hope that you will understand that these delays are unavoidable.

If you are unable to keep your appointment, please cancel as far in advance as possible. Some other patient who can be booked into the open time will be grateful for your thoughtfulness. A $25.00 no show fee may be assessed for multiple missed appointments.

Emergencies:

A provider is available on call to answer **emergency** needs after hours by calling (806) 532-2273. Only medical emergency calls will be returned.

New Patient Registration:

New patient making their first visit to the group are requested to arrive 15 minutes before their scheduled appointment for the purpose of registration. An insurance card, photo ID, and current medication list is required.

Referrals:

If you are requesting a referral to another provider for insurance purposes or continued patient care, an appointment must be scheduled with your provider to coordinate care before the referral will be submitted. For all referrals, please allow 7-10 business days for scheduling.

Medication Refills:

We require 72 hour advance notice on all medication refill requests. All requests should be submitted to your pharmacy **first.** Refill request left on the answering service after hours will not be addressed, this is for emergencies only. We will not refill antibiotics without an appointment.

Lab Results:

As an integral part of your diagnosis and treatment, our providers may order labs for continued care. If you have labs ordered by one of our providers, it is your responsibility to schedule a follow up for review. If it is a repeat lab, please contact our office in 72 hours for further instruction.

Payment for Services:

Patients are requested to pay at the time service is rendered. Payment of your account is expected within 10 days of receipt of charges. In the event that timely payment cannot be made, special and specific arrangements may be made by calling Candra Inman at (806) 532-2273.

Our requirements for payment of your account and for maintaining your account in good standing are as follows:

- All charges are due and payable within 10 days of receipt of statement.
- You are directly responsible for any unpaid balance on your account with us.
- If payment cannot be made when due, you must contact our office to set up a payment arrangement.
- After 90 days, if no payments have been received and no extended payment arrangements have been made, necessary collection proceedings will begin.
- You must notify us of any changes to your address immediately.
- In car accidents, legal cases, etc. in which an insurance company or other party is presumed liable for your expenses, incurred as a result of your accident or illness, you will be responsible for payment at the time of service. We will be more than happy to supply you with the appropriate paperwork to submit for reimbursement.

Inquiries:

If you have any questions regarding your account or the filing of your insurance, call the Business Office at **(806) 355-6593**. We will be happy to assist you.

I, _____, have read and understand the Policies and Procedures of Panhandle Family Care, LLC.

_____

Signature Date