ADVOCATE
PRIMARY CARE

370 State Hwy 121 Suite 100
Coppell, TX 75019
P: 972-382-5761 F: 855-592-2117

Today's Date:_____/_____/_____

PATIENT INFORMATION

Name:_____

Date of Birth:____/_____/_____ **Gender**: Male/Female

Marital Status: Single Married Divorced Widowed

Address:_____

City:_____ **State**:_____ **Zip**: _____

Email Address:_____

Mobile Phone:_____

Ethnicity:_____ **Race**:_____

Preferred Language:_____

Work Status:_____

Employer:_____

Occupation:_____

Parent/Guardian Name:_____

Parent/Guardian Date of Birth: _____/_____/_____

Parent/Guardian Phone:_____

EMERGENCY CONTACT

Name & Relation:_____

Phone Number:_____

PREFERRED PHARMACY

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone & Fax:_____

PRIMARY INSURANCE

Insurance Company Name:_____

Do you have any other insurance? ____ Yes _____ No

Are you the policy holder? ____ Yes _____ No

If no, what is your relation to the policy holder?

_____

Policy Holder Date of Birth:_____/_____/_____

Address:_____

City:_____ **State**:_____ **Zip**: _____

Primary Phone:_____

I, *(print name)* _____, HEREBY AUTHORIZE PAYMENT directly to the office of Advocate Primary Care any health insurance benefits payable to me but not to exceed the balance due for regular charges or treatment. I understand **I am financially responsible** to the office of Advocate Primary Care for charges not covered by this authorization and for insurance claims which are denied by the insurer. I also authorize Advocate Primary Care to release any information required to process any claims.

Patient/Guardian Signature:_____

KKNOWN ALLERGIES/ADVERSE DRUG REACTIONS

Medication or Food	Reaction
1.	
2.	
3	
4.	
5.	

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

Drug Name & Dosage	Directions	Condition
Example: Aspirin 81 mg	*1 pill in the morning*	*Heart problems*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FAMILY HISTORY

Please list any family members with a history of Alcoholism, Allergies, Anxiety, Asthma, Blood Clots, Breast Cancer, Cervical Cancer, Colon Polyps, Depression, Diabetes, High Cholesterol, Heart Disease, High Blood Pressure, Liver Disease, Lung Cancer, Melanoma, Migraine, Osteoporosis, Seizures, Stroke.

Condition/Illness	Relative(s)	Age Diagnosed/Death
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SURGICAL HISTORY

Surgery/Procedure	Date	Reason
1.		
2.		
3.		

PAST/PRESENT MEDICAL HISTORY

Condition	Date Diagnosed *(approximate)*	Current/Resolved
Example: Diabetes Type 1	*1/1/90*	*Current*
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY & RISK FACTORS

Highest Level of Education:_____
Children: ____ Yes _____ No
Tobacco Use:
___ Current Every Day Smoker
___ Current Some days Smoker
___ Former Smoker
___ Never Smoker
Passive Smoke: ____ Yes _____ No
Drug Use: ____ Yes _____ No ***If Yes, Substance*:**_____
Caffeine Use: Drinks per day?_____

How many hours per week do you exercise?_____
Family History Heart Attack in Female Age <65: ____ Yes ____No
Family History Heart Attack in Male Age <55: ____ Yes _____No

Alcohol Use: ____Yes ____No ***If Yes,***
***Drinks per day*:_____ Most common**
Type Consumed:_____

ADDITIONAL PATIENT INFORMATION

Please use this page to list any additional medications, allergies or history

CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo and suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended.

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that

1. You intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and
2. You consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with you physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to the contents. By signing this document, you agree to the statements above.

Patient/Parent/Legal Guardian Signature:_____ Date:_____

Parental Preauthorization: ***Complete this section ONLY if the patient is a minor***

I consent for _____to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent medical care, procedures and immunizations for the patient. The duration of this consent in indefinite and continues until revoked in writing.

Parent/Legal Guardian Signature:_____Date:_____

OFFICE POLICIES & PROCEDURES

Welcome to Advocate Primary Care and thank you for trusting us with your care! We strive to provide the highest quality of medical care. In an effort to foster a collaborative relationship, we ask that you accept some responsibilities as well. Please read the following and acknowledge your understanding by signing below.

Registration: All patients are **required** to complete a patient information form, patient portal and present a valid form of identification along with their insurance card before being seen by a provider.

Financial: All co-payments, deductibles, and other fees are due at the time of service. Full payment is due at the time of service unless other payment arrangements have been made prior to your appointment. Delays in insurance occur when insurance information is not provided in a timely manner. Such delays may also result in insurance not covering services provided. **When an insurance company denies payment for a service, it is the patient's responsibility to cover the charges.**

We accept the following forms of payment:

- Credit/Debit Cards
- Checks: Please note a $50 non-sufficient fund fee will be charged to your account for checks that do clear the bank.
- Cash

Cancelation and Missed Appointments: Our practice is here to serve you with the latest technology and sincere compassion. We are committed to offering you the best quality healthcare possible. We require that all cancellations be made at least 24 hours before your scheduled appointment. If we know 24 hours ahead of time that you will not be able to make your appointment, then we will be able to accommodate another patient in your time slot. Failure to give us a 24-hour notice will results in a $50 fee charged to your account. If you No Show or are late to your appointment, a $50 fee will be charged to your

account. Fees will need to be paid prior to any future appointments. Three (3) repeated missed appointments or late cancellations will results in termination of our relationship with you.

Late Arrivals: We work hard to stay on schedule to respect your time. In order to stay on schedule, we ask our patients to arrive 10 minutes prior to your appointment to give the front office and Medical Assistant appropriate time to have you ready for the provider to see you at your appointed time. If it is your first time visiting us, we ask that you arrive no later than 20 minutes prior to your appointment time. Medical emergencies can cause the providers to run behind and we ask for your patience and understanding. **Patients who arrive ten (10) minutes past their appointment time may be rescheduled for another day and be charged a $50 fee.**

After-hour Calls: If you are experiencing a life-threatening medical emergency, call 911. If you need urgent but not emergency assistance during non-business hours, please call the office. A provider is on call 24 hours a day after hours only for urgent matters, not for routine business. After hour emergency calls are handled by our answering service. They will contact the on-call provider on your behalf. **There will be a fee of $75 charged to your account if the provider is contacted after hours. Please note, the after-hour line is not for refills.** Please refer to refill policy.

Refill Policy: All prescription refill requests should originate from the patient by contacting their pharmacist asking to request the refill electronically. All refill requests should be approved or disapproved by our office within 48 hours. Routine prescription refills will not be fulfilled during the weekends or after office hours. Please plan ahead. You may also request your refills through the patient portal. This may be an easier option. All chronic, non-controlled medications will require a six (6) month follow up unless your provider recommends otherwise. Pain medications for acute pain will only be filled for ten (10) days and a follow up will be required If further refills are needed. We do not manage chronic pain in our office, and we will refer you to Pain Management if these services are necessary. Other controlled substances (ADHD medication, sleep medications, and etc.) will require a 4 month follow up.

Referrals: Please allow five (5) business days to process any non-urgent referrals.

Behavior: Physical and verbal abuse towards office staff will not be tolerated. This includes offensive behavior on the telephone with office personnel. Abusive behavior may result in immediate dismissal from the practice.

Termination Policy: We pride ourselves on our patient-physician relationship and will strive to maintain a professional and respectful relationship. Unfortunately, there may be a time when we deem a patient-physician relationship to be unhealthy due to non-compliance to treatment plan, unexpected behavior, or nonadherence to clinic policies. At this point, we have the right to terminate the relationship. We will provide a written letter to notify you of the termination. We will continue providing you care for thirty (30) days after the termination letter for urgent medical needs. This will give you appropriate time to find another provider to address your medical needs.

Patient Portal: While we encourage the use of the portal, please be aware that portal messages will NOT be answered after office hours, on weekends, or on holidays. Please use the main office phone number for emergencies/urgent matters.

Disability forms, letters, etc.: Please inform staff if you have any forms your need completed when you arrive, or by phone when you schedule an appointment. There is a fee to complete these forms. The length and complexity of the form or letter determines the amount of the fee ($10-$75).

By signing below, I acknowledge that I have read and agree to the above office policies and procedures.

Patient/Parent/Legal Guardian Signature:_____ Date:_____

Patient Communication: Patients in our practice may be contacted via email/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Advocate Primary Care. We may also send marketing and communication materials via email in order to keep you informed about our services. I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive email and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information for the following **cell phone number: _____**

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/information in the patient portal to the following **email address:_____**

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. Contact your carrier for pricing plans and details.

Patient/Parent/Legal Guardian Signature:_____ Date:_____

HIPPA Compliance Patient Consent

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. The notice is available upon request or can be reviewed in our office. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and 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 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 practice as 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 provide name, relationship, and number

1._____ 3._____

2._____ 4._____

Patient/Parent/Legal Guardian Signature:_____ Date:_____

Please notify us if you would like a copy of the HIPAA Notice Privacy Practices for your records.