WELCOME TO

KARE FAMILY CLINIC

INSURANCE CARDS ARE REQUIRED AT THE TIME OF VISIT. IF YOU ARE UNABLE TO PRESENT YOUR INSURANCE CARD, YOU WILL BE HELD RESPONSIBLE FOR ALL CHARGES, AND MUST PAY IN FULL AT TIME OF SERVICE.

PATIENT NAME: ______________________________DATE OF BIRTH: ______________

ADDRESS:___________________________CITY, STATE, ZIP:______________________

HOME PHONE:_________________CELL:_________________WORK: ______________

SSN: ______________________DRIVER'S LICENSE:______________________________

EMERGENCY CONTACT:_______________________RELATIONSHIP:_______________

PHONE NO.:__________________________WORK/CELL:__________________________

INSURANCE INFORMATION

PRIMARY INSURANCE CO.:_________________________________COPAY:_________

POLICY HOLDER:________________________DATE OF BIRTH:____________________

SSN:___________________________ EMPLOYER:________________________________

SECONDARY INSURANCE CO:_________________________________COPAY_______

POLICY HOLDER:________________________DATE OF BIRTH____________________

SSN:____________________________EMPLOYER:________________________________

ANYONE UNDER THE AGE OF 18 MUST HAVE A PARENT OR LEGAL GUARDIAN PRESENT AT THE TIME OF VISIT.

NOTICE OF PRIVACY ACT

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you.

Use and Disclosure of Your Medical Information
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed, however, we have listed all the different ways we are permitted to use and disclose medical information. We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.
For Treatment: We may use medical information about you to provide you with the medical treatment or services.
For Payment: We may use and disclose your medical information for payment purposes.
For Healthcare Operations: We may use and disclose your medical information for our health care operations.
Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name, location, and your condition described in general terms.
Notification: Medical information to notify or help notify a family member, your personal representative, or another person responsible for your care.
Disaster Relief: Medical information with public or private organization or person who can legally assist in relief efforts.
Funeral Director, Coroner, Medical Examiner: We may share the medical information of a person who has passed away.
Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medial suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order subpoena, discovery request, or other lawful process, under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect.
Victims of Abuse, Neglect, or Domestic Violence: Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations, or other authorized activities.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws, pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement officials, report regarding suspected victims of crimes at the request of law enforcement officials, reporting death, crimes on our premises, and crimes in emergencies.

You have the right to request in writing a copy of your medical record. (**There is a $20 charge that applies.**)You can indicate in writing who may have access to your records.

I have read the above Privacy Act Statement and understand the rights of Kare Family Clinic as well as my own.

Signature/Legal Guardian **Date**

KARE FAMILY CLINIC
BILLING POLICY

Due to the different insurance plans and coverage, we have implemented the following policies.

- If you are a member of a managed care plan (PPO/HMO) in which we participate, your co-pay, out-of-pocket, or deductible is due at the time of service. You can contact your insurance company for these amounts. Some co-pays are listed on the front of the insurance card.
- If we are not contracted with your insurance company, full payment is due at the time of service.
- Private pay patients are required to pay in full at time of service.
- We do NOT accept Worker's Comp/work-related injuries.
- We need a copy of your insurance card at each visit to ensure proper filing.
- If your insurance company denies a claim, it is then your responsibility to pay any unpaid charges. If you have any questions regarding an unpaid claim please contact our billing office at **972-613-5379.**
- In some cases the insurance company may request additional information from you, if you fail to comply in a timely manner the insurance can and will deny your claim. You will then be responsible for all charges.
- We accept: Master Card, Visa, Discover, Money Orders, Checks, and Cash. We process all checks electronically.
- If you have a returned check, a certified letter will be mailed to you to inform you of this. There is a **$30.00** charge for all returned checks. This will need to be cleared within 10 days of receipt of your certified letter otherwise checks will be turned over to the District Attorney. You will be responsible for any charges incurred. If you have a NSF, you and your family members will be unable to be seen until the matter is resolved. If we receive more than 2 NSF checks we will no longer be able to accept checks from you.
- For all Disability forms, FMLA, or DME equipment request we require **48-72 hours** for completion. There is a **$20.00 charge** for all paperwork.
- It is your responsibility to notify the office of insurance and address changes.
- All minor patients (17 and younger) must have a parent/legal guardian present for all office visits.

I have read the office policies for Kare Family Clinic and understand them. My signature below is acknowledgement and receipt of policy.

___

Patient/Legal Guardian Signature **Date**

KARE FAMILY CLINIC
COMMUNICATION/AUTHORIZATION RELEASE FORM

I HEREBY GIVE PERMISSION TO KARE FAMILY CLINIC STAFF TO NOTIFY ME BY TELEPHONE OR MAIL THE FOLLOWING:

CHECK ALL THAT APPLY:

YES___NO___: APPOINTMENT REMINDER, PERSONAL MESSAGE OR RECORDED MESSAGE.

YES___NO___: TEST RESULTS.

YES___NO___: REFERRAL TO SPECIALISTS

YES___NO___: YOU MAY MAIL A LETTER TO MY HOME ADDRESS IN REGARDS TO TEST RESULTS AND/OR REFERRAL INFORMATION. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO MAKE SURE THIS INFORMATION IS CURRENT.

THE INDIVIDUALS LISTED BELOW ARE AUTHORIZED TO RECEIVE AND INQUIRE ABOUT MY MEDICAL RECORDS ON MY BEHALF:

____

RELATIONSHIP TO PATIENT

____

RELATIONSHIP TO PATIENT

____

RELATIONSHIP TO PATIENT

I UNDERSTAND THIS FORM IS INTENDED TO GUARD MY PRIVACY AND IS NOT A RELEASE OF GENERAL MEDICAL INFORMATION.

____

PATIENT/LEGAL GUARDIAN DATE

PATIENT MEDICAL HISTORY

NAME____DATE OF BIRTH________________

DO YOU SMOKE________HOW MUCH_______________DO YOU DRINK_____________

ANY DRUG ALLERGIES____

HAVE YOU EVER BEEN HOSPITILIZED? _______ DATES/DIAGNOSIS________________

ANY SURGERIES? LIST TYPE/YEAR____

NUMBER OF PREGNANCIES____MISCARRIAGES___DATE OF LAST PAP SMEAR____

DO YOU HAVE REGULAR PERIODS? ____

FATHER'S AGE_____ANY HEALTH PROBLEMS__________________________________

MOTHER'S AGE____ANY HEALTH PROBLEMS___________________________________

DO YOU HAVE ANY BLOOD RELATIVES WHO ANY OF THE FOLLOWING HEALTH PROBLEMS?

DIABETES	YES	NO	WHO______________________________
HIGH BLOOD PRESSURE	YES	NO	WHO______________________________
HEART ATTACT	YES	NO	WHO______________________________
STROKE	YES	NO	WHO______________________________
STOMACH ULCERS	YES	NO	WHO______________________________
CANCER	YES	NO	WHO______________________________
FREE BLEEDING/ANEMIA	YES	NO	WHO______________________________
SEIZURES/EPILEPSY	YES	NO	WHO______________________________
NERVOUS DISORDERS	YES	NO	WHO______________________________
TUBERCULOSIS/ASTHMA	YES	NO	WHO______________________________
BRONCHITIS/EMPHYSEMA	YES	NO	WHO______________________________
KIDNEY STONES/CYST	YES	NO	WHO______________________________

DO YOU HAVE ANY HEALTH PROBLEMS

PERSISTANT WEIGHT GAIN/LOSS	YES	NO	SKIN DISORDERS	YES	NO
VISION PROBLEMS	YES	NO	RINGING IN EARS/DIZZY	YES	NO
FREQUENT NASAL CONGESTION	YES	NO	DIFFICULTY CHEWING	YES	NO
DIFFICULTY SWALLOWING	YES	NO	BREAST LUMP/DISCHARGE	YES	NO
COUGH W/SPUTUM	YES	NO	SHORTNESS OF BREATH	YES	NO
CHEST PAIN	YES	NO	SWELLING FEET/LEGS	YES	NO
INDIGESTION/HEART BURN	YES	NO	SKIN DISORDERS	YES	NO
FREQUENT URINATION	YES	NO	CHANGE IN STOOL COLOR	YES	NO
CONSTIPATION	YES	NO	DIARRHEA	YES	NO
BURNING URINATION	YES	NO	SLOW STREAM	YES	NO
BONE & JOINT PAIN	YES	NO	NERVE DISORDER	YES	NO
FEMALE PROBLEMS	YES	NO	MALE PROBLEMS	YES	NO

DO YOU HAVE ANY OTHER HEALTHE PROBLEMS NOT LISTED ABOVE?

CURRENT MEDICATION LIST

NAME: ______________________________ BIRTHDATE:____________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATION. MAKE SURE TO LIST NAME, STRENGTH OF MEDICATION, AND HOW YOU TAKE EACH ONE.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____
15. ____
16. ____