Sugar Lakes Family Practice

PATIENT INFORMATION

Name: Last:_____First:_____MI:_____Preferred:_____

Date of Birth:_____SSN:_____Gender:_____Male____Female

Marital Status:_____Race:_____Ethnicity:_____Language:_____

Home Address:_____City:_____State:_____Zip:_____

Home Phone:_____Work Phone: _____Cell Phone:_____

Email:_____Employer:_____

Primary Care Physician:_____

EMERGENCY CONTACT

Name:_____Phone:_____Relationship: _____

PHARMACY INFORMATION

Local Pharmacy:_____Phone:_____

Address:_____

Mail Order Pharmacy:_____Prescription ID:_____

Phone:_____ Fax:_____

INSURANCE INFORMATION

Insurance Name:_____

Insurance ID:_____Group Number:_____

Policy Holder Name:_____DOB:_____SSN:_____

Policy Employer:_____

I hereby authorize direct payment of medical benefits of Sugar Lakes Family Practice for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I also authorize a release of my medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I certify that the information given by me in applying for payment is correct. I authorize release or reports on request. I request that payment of authorized benefit be made on my behalf. A photocopy of the assignments shall be valid as original.

Patient Signature: Date:

Sugar Lakes Family Practice

Last Name:_____ First Name:_____ DOB:_____

Occupation:_____ Religion:_____

PATIENT MEDICAL HISTORY

Prescription Medication:_____

_____

_____

Over the counter Supplements:_____

_____

Medical Problems:_____

_____

_____

Surgical History:_____

_____

_____

Allergies:_____

_____

Do You Use:

Tobacco or Smoke:_____ Amount Daily:_____ How many years:_____

Recreational Drugs:_____ Type:_____ Alcohol:_____ Quantity Weekly_____

Last Colonoscopy:_____ Last Mammogram:_____

Last Bone Density:_____ Last Dental Exam:_____

Recent Vaccination Year:

Tetanus:_____ Flu:_____ Pneumonia:_____ Shingles:_____

Females:

LMP:_____ Number of Pregnancies:_____ Miscarriages:_____

Do you have an Advance Directive: _____

FAMILY MEDICAL HISTORY

	Alive/Deceased	Years Born	Medical Problems
Father			
Mother			
Children			
Siblings			

	Medical Problems
Paternal Grandparents	
Paternal Aunts/Uncles	
Maternal Grandparents	
Maternal Aunts/Uncles	

History of Cancer (If yes, Type/Who):_____

_____

History of Psychiatric Diagnoses (If yes, Type/Who):_____

Children Names/DOB:_____

Patient Signature Date

16902 SW Frwy Suite 100 Sugar Land TX 77479
Phone: 281-565-2800 Fax: 281-565-2801

Sugar Lakes Family Practice

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Sugar Lakes Family Practice.

Name of Patient (Print):_____

Signature of Patient or Guardian:_____

Date:_____

For medical results, please contact me at the following numbers:

(please do not list number you do not wish to be called)

Work:_____

Cell:_____

Home:_____

My medical results and/or documents can be given to:

Spouse(name):_____

Other(name):_____

Sugar Lakes Family Practice reserves the right to modify privacy practices outlined in notice.

Sugar Lakes Family Practice

Financial Policy

Thank you for choosing us as your primary healthcare provider. We are committed to providing you with quality and affordable health care and need your assistance and understanding of our payment policy. We ask you to review and sign this policy, asking questions as necessary.

Insurance: We accept and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Our office will file an insurance claim for you for services rendered and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

Patient payment: Copayments and deductibles are due at the time of service. This arrangement is part of your contract with your insurance company.

Insurance Coverage Changes: If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

Uninsured or Self pay patients*:* We offer a discount to our patients who do not have insurance. Please be advised that the discount is only good when charges are paid on the day of service. If the charges are not paid at the time of service, the discount will be removed, and payment of the full charge will be expected before the next visit. If a balance remains, you will receive a monthly statement that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.

Forms: There is a $25 fee for completing forms (including FMLA, sick leave, AFLAC, disability insurance forms, etc.) and a $5 fee for picking up controlled substance prescriptions. These form fee must be paid when forms are submitted to our office for completion, prescription fee is due upon pick up.

Financial Responsibility for Minors: Unless prior arrangements have been made, charges for minor child seen in the office will be the responsibility of the adult accompanying the minor child.

Returned Checks: Returned checks are subject to a **$25.00 charge**.

Medical Records Request: There will be a **charge of $25 or more (depending on # of pages)** for every medical records request.

Credit and collection: If your account is more than 90 days past due, you will receive a letter stating that you have an outstanding balance and must make payment at that that time. Partial payments (i.e. payment plans) will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, our office reserves the right to discharge the patient from the practice. In this event, the patient will be notified that you will need to find alternative medical care.

Phone management fee: There may be a $25 charge for managing and treating minor acute illnesses (e.g., cold, flu, or sinus congestion) over the phone. The phone management fee will not be billed to your insurance and is your full responsibility. Payment will be collected over the phone and you can request a receipt. Thank you for understanding our financial policy.

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

Please let us know if you have any questions or concerns. I have read, understand and agree to abide by the financial policy set forth.

_____ _____

Signature of Patient/Responsible Party Date

Sugar Lakes Family Practice

Controlled Substance Prescription Consent and Agreement

The following is an agreement between the patient and healthcare providers of this practice to establish clear guidelines for the prescription and use of controlled substances. This includes medications prescribed to treat conditions such as pain, anxiety, sleep disturbance and attention deficit disorder. This is to help ensure the safety of the patient and compliance with the law regarding these medications.

I will

- Fully and accurately communicate to my provider the character and intensity of my symptoms, the effect these symptoms have on my daily life and how well the medicine helps to relieve the symptoms.
- Safeguard my medications from loss or theft and understand lost or stolen medications will not be replaced.
- Request controlled substances (including refills) only at office visit or during regular business hours, no prescriptions will be provided during evenings and/or weekends.

I will not

- Share my prescriptions with any other individuals
- Attempt to obtain new prescriptions or refills for controlled substances from other healthcare providers without informing my prescribing provider at this practice
- Use my prescribed controlled substances along with alcohol, sleep medications of other substances/medications that may cause drowsiness
- Increase my dose and/or frequency without my provider's permission under any circumstances
- Call for refills earlier than they are due

I understand

- That controlled substances have potential side effects including addiction, liver/kidney damage, allergic reactions, drowsiness and mental impairment.
- That if there is no evidence of improvement in symptoms (pain, anxiety) and/or my quality of life with use of the prescribed medications, they may be discontinued
- If I am referred to another healthcare provider or treatment (i.e. specialist. Pain management, physical therapy, counseling) and I fail to follow through with this recommendation, my medications may be discontinued
- I will be required to follow up with my provider regularly and no less than every 6 months
- Medications will not be refilled early due to travel, patient using medications at higher dose/frequency than prescribed (unless previous consent given by prescriber)

I consent to

- My provider reviewing my medical records from other treating providers or pharmacies
- Random drug testing and/or random pill counts from the healthcare provider

By signing below, I agree that I understand the terms of this contract and will ask for clarification of any issues that I do not understand. I consent to treatment of my condition(s) with controlled substances. I understand that my failure to abide by the terms of this agreement may result in the discontinuation of prescribed controlled substances and termination of the doctor-patient relationship.

_____ _____

Patient or Patient's Guardian Date

Sugar Lakes Family Practice

Patient Name_____ Date of Birth_____

Informed Consent to use Patient Portal

Sugar Lakes Family Practice is offering this secure, HIPAA compliant communication tool to allow communication with the nurse/provider, to obtain lab results and access to your medical records. It is an optional service and we reserve the right to suspend or terminate it at any time. We will alert you to any changes as promptly as possible. By signing below, you confirm that you have read, understand, and agree to comply with our procedures and guideline for using the patient portal. You also agree not to hold Sugar Lakes Family Practice or any of their staff liable for network infractions beyond their control.

Privacy and Security

The web portal or web page has a secure tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information. To help ensure that the tunnel remains secure we need to have you current (private) email address and be informed if it ever changes. Your email address is confidential and protected information. All access to our internal network and electronic medical records is password protected.

_**Yes**, I would like to sign up __**No**, I do not want to sign up

Email:_____

Signature: _____ Date _____

(Patient or Guardian)