GAINESVILLE CLINIC
A Premier Independent Physicians Practice

Patient Name:_____

Demographic Information

Patient Name	**Date of Birth**	**Sex** ◯Male / Female◯
Email		**Marital Status** ◯Single ◯Married ◯Widowed ◯Divorced ◯Other
Mailing Address	**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**How did you hear about us?** ◯Google ◯Physician Referral ◯Other: _____

Primary on Insurance Coverage ◯Self ◯Other – Please complete information below.

Name		**Relationship to Patient**
Date of Birth	**Primary Phone**	**Mailing Address** [☐ Check if Same as Above]

Employer's Name

Emergency Contact Name and Relationship	**Emergency's Primary Phone**	**Emergency's Secondary Phone**

I authorize detailed messages containing medical information about me and my care in a voicemail at the following numbers:
☐ Primary Phone ☐ Secondary Phone ☐ Emergency Primary ☐ Emergency Secondary

Pharmacy Name and Address	**Pharmacy Phone Number**
Ethnicity ◯Hispanic or Latino ◯Not Hispanic or Latino ◯Unknown	**Preferred Language** ◯English ◯Other_____
Race ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Other ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander	**Appointment Confirmation Preference** ☐ Email ☐ Text

Protected Health Information Authorization

Name	Relationship	Type of Information Authorized
1.		☐All ☐Scheduling ☐Medical ☐Billing
2.		☐All ☐Scheduling ☐Medical ☐Billing
3.		☐All ☐Scheduling ☐Medical ☐Billing

I have reviewed the information below and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization in writing at any time.

_____ _____
Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary
Insurance Company	**Insurance Company**
Name of Insured	**Name of Insured**
Member ID/ Policy #	**Member ID/ Policy #**
Group #	**Group #**

Patient Name:_____

Patient Financial Policy Sheet

We have developed the following Patient Financial Policies to ensure a clear understanding between our patients and our business office. If you have any questions regarding these policies, please discuss them with us. We are committed to providing exceptional care to you and consider your understanding of your financial responsibilities as an essential element of your care. Unless other arrangements have been made in advance, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, American Express, Discover, Mastercard, or Visa.

Your Insurance

We have contracted with many health insurance plans to accept an assignment of benefits. This means that we bill those plans, and you may be required to pay a copayment, coinsurance, or deductible at the time of service. The benefits provided at time of service are an estimate, not a guarantee of your out-of-pocket cost.

Your help in ensuring payment of your health insurance claims may be required. If your health plan requires a prior authorization in the form of a **referral** from your primary care provider (PCP), or **precertification** before procedures or treatment may be initiated, please inform our staff so that these arrangements are made in advance.

We will bill your secondary coverage if we are contracted with the plan.

If you have health insurance plan for which we are not contracted, we will prepare and send claims on your behalf. Please be aware that the patients' responsibility owed when using non-contracted providers will usually be more than when using contracted providers.

Not all services are a covered benefit in all health insurance plans. Some health insurance plans select certain services that will not be covered. If your health insurance plan determines a service to be “not covered,” you will be responsible for the complete cost of the service.

Payment of your "patient responsibility" balance as determined by your health insurance plan is due upon receipt of a statement from our office.

If you have not received a notice of payment from your health insurance plan within 30 to 45 days, please contact them to discuss any issues causing delays. You will be responsible for services not paid by your health insurance plan.

Minor Patients

For all services rendered to minor patients, the parent or guardian or the adult accompanying the minor will be responsible for payment.

Acknowledgement

I have read and understand Gainesville Clinic's Patient Financial Policy, and I agree to its terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient | Signature of Patent/Legal Representative | Date

Notice of Receipt of Privacy Practices Notice Acknowledgement

Gainesville Clinic reserves the right to modify the privacy practices outlined in the notice.

I have reviewed or have been given the opportunity to review Gainesville Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices. *If you would like to receive a copy of our Notice of Privacy Practice, please request from the front desk or visit our website.*

Printed Name of Patient | Signature of Patent/Legal Representative | Date

□ Aubrey	□ Denton	□ Grand Prairie	□ McKinney	□ Pilot Point	□ Sanger	□White Rock	□Decatur	□Gainesville
972-347-2777	940-566-5010	972-266-5354	214-491-5606	940-686-2254	940-458-0112	214-328-3610	940-627-7440	940-580-3070

Patient Name:_____

Cancellation, No Show, and Late Arrival Acknowledgement

To minimize patient wait times and improve appointment availability, Gainesville Clinic has implemented a **Cancellation**, **No Show**, and **Late Arrival Policy**.

If a patient cancels an appointment with less than 24-hours' notice or does not arrive for their appointment, they will be **charged $35.00** for the missed appointment. After two cancellations or no shows without advanced notice, the practice may be unable to schedule the patient's appointments in the future.

If a patient arrives 15 minutes or later to their scheduled appointment may be asked to reschedule their appointment.

I understand Patient Cancellation, No Show, and Late Arrival Policy.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

Prescription Policy

Gainesville Clinic's practices are medical offices which treat many types of conditions and occasionally, you may be prescribed medications to help relieve pain. These medications, when used properly, help patients feel better and lead productive lives. These medications can also be misused.

For this reason, the State of Texas and the Federal Drug Enforcement Administration regulates use of these medications. Gainesville Clinic's practices follow those laws and have adopted the following policy.

Our Policy

1. Please allow **72 business hours** for prescription request processing.
2. Requests to transfer ADD/ADHD medications to a different pharmacy after the prescription is sent will incur a $10 fee per prescription.
3. Written prescriptions will not be replaced if lost, stolen, destroyed, or misplaced.
4. Prescriptions are to be taken as directed. Do not change the frequency of the dose unless otherwise directed by your provider. If a change does occur, this will be documented in your chart.
5. By law, controlled substances cannot be refilled over the phone.
6. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in our office in the last three months, prescriptions for the following medications cannot be refilled. Exceptions to this must be discussed with your provider during an office visit. Exceptions will not be granted over the phone.
    a. Sleep Aids such as Ambien or Lunesta
    b. Anti-inflammatories such as Celebrex, Ibuprofen, or Naproxen
    c. Narcotics such as Lortab, Vicodin, Darvocet, or Hydrocodone
    d. Muscle Relaxers such as Soma, Flexeril, or Robaxin.
7. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, contact our office and schedule an appointment.
8. Refills will **not** be authorized at night, on weekends, or holidays. Please plan ahead to be sure you have enough medication.
9. Before you visit our practice, please check your supply of medication. If you need refills, please ask for them during your appointment.
10. Refill requests for hormone replacement and birth control pills can only be refilled if you have a routine gynecology appointment scheduled. Exceptions to this must be discussed with your provider during an office visit. Exceptions will not be granted over the phone.
11. Refill requests for prescriptions not prescribed by your provider will not be authorized.
12. Please do not contact the office more than once about a medication or refill. Your provider is the only person who can approve for your medication to be refilled.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescriptions refilled. I agree to this policy and understand that this signed policy will be scanned into my chart.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

Patient Name:_____

Permission to Release your Protected Health Information

This is a release form for permission for your medical information to be used/and or disclosed between health care providers health, insurance companies, and any other party involved in your medical care.

I, _____DOB_____, hereby authorize the Providers listed below to release all medical information to Gainesville Clinic. **Gainesville Clinic – Fax Number: (940) 580-2042**

This request includes hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.
Please list the names and fax numbers of the providers/doctors you see so they may share your records with us.

Provider/Doctor Name	Fax Number

I hereby authorize the above-mentioned provider/facility to release and/or disclose the medical information as indicated below to: Gainesville Clinic. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health and alcohol and/or substance abuse.

Effective Time Period: This authorization is valid until the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date: Month _____ Day _____ Year _____.

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Gainesville Clinic. I understand that prior actions taken in reliance on this authorization will not be affected.

Redisclosure: I understand that Gainesville Clinic may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED

☐ Entire medical record ☐ History and Physical ☐ Chart Summary ☐ Labs ☐ Radiology ☐ Pathology

☐ Other (Please specify) _____

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING INFORMATION:

_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Testing Results)

_____Drug, Alcohol, or Substance Abuse Records _____HIV/AIDS Test Results/Treatment

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purpose only:

☐ Physician or Healthcare facility ☐ Legal ☐ Personal ☐ Other _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

_____ _____ _____

Printed Name of Patient Signature of Patient/Legal Representative Date

Patient Name:_____

Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment. I consent to any diagnostic procedures and tests that the providers, their associates, assistants, and other healthcare providers determine to be medically necessary.

During the course of treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result of the treatment.

I consent to the taking of photographs or imaging related to the care and treatment and understand that such photographs or imaging may be a part of the medical record and/or used for internal purposes such as training.

I have the legal right to consent to medical treatment because I am the patient or I am the parent/legal guardian of the patient.This is a release form for authorization of your medical information to be used/and or disclosed between health care providers health, insurance companies, and any other party involved in your medical care.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

Permission to Text and Email

By signing below, I authorize Gainesville Clinic through its partners including but not limited to Summus Healthcare, LLC, SimpleTexting, and MailChimp to contact me by SMS text message to better serve me. Gainesville Clinic will send me text messages and/or emails to help me stay healthy including reminders about appointments, information about making healthy choices, and information about additional services.

I understand that message/data rates may apply to messages sent through Gainesville Clinic to my cell phone and that I may receive up to 2 texts or emails per month in addition to appointment reminders.

I know that I am under no obligation to authorize Gainesville Clinic to send me text messages and/or emails.

I may opt-out of receiving these communications from Gainesville Clinic at any time by calling my provider's office, emailing printandmedia@premiersummus.com, texting STOP in response to a text message, or using the unsubscribe function within any email I receive from Gainesville Clinic.

☐ I consent to receiving text messages.
☐ I consent to receiving email messages.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

Patient Portal Consent Form

A patient portal is a web portal which allows patients to view and reach their medical records which include lab results, medical history, and medications. The patient can access the secure Patient Portal via the internet.

Please refer to our HIPAA policy for information on how protected health information (PHI) is used at Gainesville Clinic. All patients have signed a HIPAA agreement form and have been offered a copy of our policies.

While we believe that we have created a safe and secure IT infrastructure to house data, it does not guarantee that unforeseen adverse events cannot occur. Gainesville Clinic has undertaken rigorous IT implementation and enforced security standards exceeding industry standards.

Printed Name of Patient | Signature of Patient/Legal Representative | Date

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Patient Name:_____

Medical History (Page 1)

Name		Date			
DOB		Age		Sex	

Briefly describe your present symptoms or the reason for your visit:

PAST PHYSICIAN/HOSPITAL HISTORY

Allergies ◯yes ◯no

Allergy: What reactions did you have?

_____

_____

Name of physician/clinic	Duration of treatment (month or year)	Location (city/state)	Reason for treatment

Have you ever been hospitalized? ◯no ◯yes (if yes please fill in below)

Name of hospital	Date of hospitalization	Location (city/state)	Reason for treatment

Immunizations (*for minors, please provide a copy the current immunization record.)*

What was the date of your:

last tetanus vaccination? _____

Flu vaccination? _____

Pneumonia vaccination? _____

Hepatitis B vaccination? _____

COVID vaccination? _____

Shingles vaccination? _____

Female patients:

Number of pregnancies:_____

Number of deliveries:_____

Date of menstrual period:_____

Date of pap smear: _____

Date of last mammogram: _____

What method of birth control do you use? _____

Male patients:

Manual prostate exam:_____

PSA blood test:_____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- □ Diabetes
- □ Heart murmur
- □ Crohn's disease
- □ High blood pressure
- □ Pneumonia
- □ Reflux/heartburn
- □ Bleeding disorder
- □ Anemia
- □ Hypothyroidism
- □ Asthma
- □ Jaundice
- □ Goiter
- □ Emphysema/COPD
- □ Hepatitis
- □ Cancer (type) _____
- □ Stroke
- □ Stomach or peptic ulcer
- □ Leukemia
- □ Migraine headaches
- □ Depression
- □ Epilepsy (seizures)
- □ Rheumatic fever
- □ Psoriasis
- □ Cataracts
- □ Tuberculosis
- □ Angina
- □ Kidney disease
- □ HIV/AIDS
- □ Heart problems
- □ Kidney stones
- □ Glaucoma
- □ Other pertinent history _____

Patient Name:_____

Medical History (Page 2)		
SURGERIES, EXAMS, AND TESTS - Please include the date of any surgeries, exams, or tests.		
Tonsil:	Ortho (Bone):	Cologuard/Colonoscopy:
Gallbladder:	C- Section	Electrocardiogram (EKG]:
Appendix:	Colon:	Complete Physical:
Hysterectomy:	Bladder:	Chest X- Ray:
Heart:	Hernia:	Treadmill Stress:
Lung:	Breast:	

CURRENT MEDICATIONS

Please list any medications that you are currently taking. Include non-prescription medication & vitamins or supplements: Please include name of drug, dose, how many times per day, and how long have you been taking each medication.

1		7	
2		8	
3		9	
4		10	
5		11	
6		12	

SUBSTANCE ABUSE HISTORY

Are you a smoker? ◯Yes◯No
If yes, how many packs do you smoke per day? _
_____Any attempts to quit? _____
If you quit smoking, when did you quit? __

Do you consume alcohol?◯Yes◯No
How often do you drink? □ Weekly _____/ wk. □ Monthly _____/month □ Rarely _____
□ Quit drinking (Please provide your last usage)

Do you have a history of substance abuse? □
Yes □ No Have you ever attended rehab? □
Yes □ No
If yes, please state when and what kind of treatment: _____

Substance	Quantity Used	Frequency of Use	Quit (Y/N)	Last Used

Patient Name:_____

FAMILY HISTORY Please list blood relatives who have been diagnosed with the following conditions.	
Is your father living? □ Yes □ No	If not, what was the cause of death?
Is your mother living? □ Yes □ No	If not, what was the cause of death?
Alcoholism	Heart Disease/high blood pressure/irregular heart rhythms
Anxiety disorders	Osteoporosis
Bipolar disorder	Seizures
Cancer	Schizophrenia
Depression	Stroke
Diabetes	Suicide
Drug abuse	Thyroid disease

SOCIAL HISTORY

Relationship Status: □ Single □ Married □ Divorced □ Widowed □ Long-term partner

How long have you been married?

Employment status: □ Full-time □ Part- time □ Unemployed □ Retired □ Disabled □ Homemaker □ Student

Occupation: _____Employer: _____

How long have you had this job: _____

Residential status: □ Own a home □ Rent □ Live with parents □ Foster care □ Homeless □ Nursing home facility □ Live with roommate(s)