Family Care Clinic

Making families whole...inside and out.

WELCOME!

Patient Registration

Please Print

Patient Information

Patient's Full **Legal** Name: _____ SS#_____

DOB: _____/_____/_____ Age:_____ Sex: **M F** Marital Status.: **S M D W** Race _____

Mailing Address: _____ City:_____ Zip_____ County_____

Complete **Residentia**l Address (if different): _____

Cell phone: _____ home Phone: _____

EMAIL _____

Employer: _____ **Occupation**: _____

Employment Phone: _____ Ext: _____ Dept: _____

In case of emergency, please notify: _____ Phone:_____
Relationship to patient: _____

Fill out this section if patient is NOT the insurance Policy Holder. (GUARANTOR'S information)
Name of Insured: _____ Insured's DOB: _____
Insured's SS#_____ Insured's Phone: _____
Insured's Address: _____ City: _____State____ Zip:_____ County _____
Insured's Employer: _____ Occupation: _____work phone _____
Name of Insurance: _____ Insurance Phone: _____
Insured's ID #_____ Group #_____
Relationship to the Guarantor: **SPOUSE CHILD STEPCHILD GRANDCHILD OTHER**

How did you hear about the Family Care Clinic? [ ] Friend (Name) _____
[ ] Newspaper [ ] Physician (Name) _____ [ ] Yellow Pages Ad
[ ] School Teacher Referral (for ADD) [ ] Ennis Now Magazine [ ] Corsicana Now Magazine
[ ] Waxahachie Now Magazine [ ] Attended a lecture by Dr. Laws

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Patient's Responsible Party

This section must be filled out if the patient is a minor AND the patient's responsible party is not the insured.

Name: _____
Complete Mailing Address: _____ City: _____
Zip: _____ Home Phone: _____ Other Phone: _____

Responsible Party Agreement

Method of Payment: Cash _____ Credit Card_____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE.

X SIGNATURE: _____ DATE: _____

Family Care Clinic
717 W. Lampasas St.
Ennis, TX 75119

Patient Preference Regarding Communication of Health Information

Patient: _____ DOB: _____

I. Who to Contact

I hereby give permission to the Family Care Clinic to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

☐ **I DO NOT** wish to give permission for family members, relatives, or close personal friends to have access to any information regarding my medical condition.

II. How to Contact

I wish to be contacted in the following manner:

HOME TELEPHONE ( ) -	**CELL** TELEPHONE ( ) -
[ ] OK to leave message with detailed information [ ] Leave message with call-back number only	[ ] OK to leave message with detailed information [ ] Leave message with call-back number only
WORK TELEPHONE ( ) -	

[ ] Written Communication:
- [ ] OK to mail to my home address:_____
- [ ] OK to mail to my work/office address: _____
- [ ] OK to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

_____ _____
Signature of Patient or Legal Representative Date

Financial Statement and Policies for the Family Care Clinic

Below you will find a list of financial policies for the Family Care Clinic. Please read and sign this statement to affirm that you have read, understand, and agree to these policies.

1. Please bring your insurance card with you to every visit. If you do not have an insurance card, we will treat you as a cash patient.
2. Patient balances must be paid in full before seeing the doctor or receiving prescription refills.
3. Co-pay is due at check-in.
4. Please review what your insurance covers so you understand whether or not you will be responsible for labs and/or procedures.
5. A $25.00 cancellation fee will be applied if an appointment is not cancelled within 24 hours of the scheduled time.
6. Refills will not be authorized after regular office hours.
7. Patient responsibility balances must be paid in full before seeing the doctor.
8. No checks will be accepted on the first visit. Please pay with cash or a credit card.
9. A $25 NSF fee will be applied to any returned checks.
10. If your insurance company, including Medicare, does not pay for a service, procedure, labs, or injections, you will be responsible for that balance regardless of whether or not your insurance company has transferred this balance to your responsibility.
11. There will be a $25 late fee applied to any balances after 30 days from the date of the first notice. If we have to send your bill to a collection agency, a $35 fee will apply.
12. There will be a $10.00 charge to replace lost prescriptions or if they need to be re-written because they have expired. (Prescriptions for controlled substances must be filled in 21 days by law).
13. There is a charge for any papers or forms dropped of that need to be filled out by a Provider.
14. A deposit is required for all new patient appointments in the amount of their copay or deductible according to your plan. This is non-refundable if the appointment is not kept or cancelled.
15. You will be released from the practice if you have excessive No Shows or Cancelled appointments.

I have read, understood, and agree to adhere to the policies of the Family Care Clinic.

_____ _____

Signed Date

D. Blayne Laws, MD, P.A.

Acknowledgment of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this office'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.

_____
Name of Patient (**Print or Type**)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

Family Care Clinic
D. Blayne Laws, M.D.
717 W. Lampasas St.
Ennis, TX 75119

CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

Address: _____

Telephone Number: _____ Date of Birth: _____

1. I, _____, (the_____ of _____) hereby voluntarily consent to outpatient care at the office of D. Blayne Laws, M.D., encompassing routine diagnostic procedures, examinations and medical treatment, including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of x-rays, heart tracing, and administration of medications prescribed by the physician.

2. I further consent to the performance of those diagnostic procedures, examinations and Rendering of medical treatment by the medical staff, their assistants, including physician's Assistants or their designees as are necessary in the medical staff's judgment.

3. RELEASE OF INFORMATION: (A) I authorize the clinic to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my (his/her) medical care. (B) I further authorize the release of medical information about medical treatment here to my (his/her) doctor or any designated by me.

4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend(s) the office of D. Blayne Laws, M.D.

5. This form has been fully explained to me, and I understand its contents.
Comments: _____

_____ _____

Patient Signature or Signature of Individual Authorized to Sign for Patient

Witness

Family Care Clinic
ePrescribing Consent Form

ePrescribing is now being mandated by Congress for the purpose of providing error free, accurate prescriptions to a pharmacy from a physician. The *Medicare Modernization Act* of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that the Family Care Clinic can request and use your prescription medication history from other healthcare providers and or/third party pharmacy benefit payors for treatment purposes.

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[ ] Understanding the above, I hereby provide informed consent to the Family Care Clinic to enroll me in the ePrescribe Program.

_____	_____
Patient's Printed Name	Patient's DOB
_____	_____
Patient's Signature (**Parent's signature is required for Minors**)	Today's Date

OR

[ ] Refusal to be enrolled in ePrescribe. By checking this box I am stating that I will be getting all prescriptions from another physician.

_____	_____
Printed Name	DOB
_____	_____
Signature	Date