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.

- -

[ ] 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 ______________________

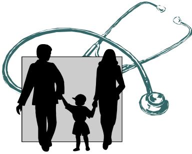
Patient's Signature ______________________ Today's Date ______________________
(**Parent's signature is required for Minors**)

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 ______________________



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
Complete Mailing Address: ______________________________ City:____________ Zip:_____________
Complete Residential Address (if different): ____
Home Phone: ____________________________________ Other Phone: _____________________________

In case of emergency, please notify: _______________________________ Phone:____________________
Relationship to patient:______________________________

Fill out this section if patient is not the insurance policy holder.
Name of Insured: _____________________________________ Insured's DOB: _______________________
Insured's SS#_________________________ Insured's Phone: ____________________________________
Insured's Address: _________________________________ City: ________________ Zip:_____________

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

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

SIGNATURE:____ DATE: _____________________________

Text Message Consent

I hereby give consent to receive text message appointment reminders and correspondence from my healthcare provider. I understand that consent is not a condition of receiving service. I understand and agree that any text message I receive may be sent by autodialer.

Phone number to receive text messages: ______________________________

___________________________________ ___________________________ ______________________

Signature of patient/guardian Name of patient/guardian 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

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

CONSENT FOR TREATMENT

Patient Name: ______________________________ Date: ______________________________

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.

___________________________________ ______________________________

Patient Signature or Signature of Individual Authorized to Sign for Patient **Witness**

Acknowledgement 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 undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

____
Signature of Patient/Guardian

____
Date

Financial Statement 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.

My policy with my insurance company is a contract between me and my insurance and it is my responsibility to:

1. Bring my insurance card and photo ID with me to every visit. If I do not have an insurance card, I will be considered a cash patient. If I fail to provide new insurance information, I will be responsible for the full balance and it will be my responsibility to file with my new insurance company. No refunds or adjustments will be refunded at a later date.
2. Pay balances in full, or make payment arrangements, **before** seeing the doctor.
3. Pay my Co-pay at check-in. Pay deductibles or co-insurance at the time of service. I will also be responsible for any services not covered by my insurance or if the claims are not paid in a reasonable amount of time. Post-dated checks will not be held as payment.
4. Pay the full amount due at the time of service if I am a cash pay patient.
5. **Pay a $25.00** cancellation fee if an appointment is not cancelled within 24 hours of the scheduled time.
6. **Pay a $50.00** cancellation fee if an appointment is cancelled less than 12 hours from the scheduled appointment time or if I no show for my appointment.
7. Pay with cash or a credit card. No checks will be accepted on the first visit.
8. Pay a $25 NSF fee for returned checks.
9. Pay a $25 late fee applied to any balances after 30 days from the date of the first notice. If I do not pay the balance or make payment arrangements in 30 days from the first notice my account will be turned over to collections and a $35 fee will apply.

The Family Care Clinic will do their best to understand your benefits for each visit. However, because of the large number of insurance plans we will not be able to know all aspects of each plan.

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

______________________________ Signed

______________________ Date

Family Care Clinic

D. Blayne Laws, MD

Medication Policies

1. Policies on Controlled Rxs:
   a. Due to the regulated nature of the stimulant/pain medications:
      i. You will need to see Dr. Laws every 3 months. Exceptions will be made on a case by case basis.
      ii. Your prescription will be written for 30 or 90 days.
      iii. For a 30 day RX, 3 prescriptions will be sent with a different "fill by" date. You will need to fill these prescriptions within 21 days of the fill-by date or they will expire**. We will not write a new rx for an expired prescription.**
      iv. For a 90 day Rx, a new prescription must be written each time.
   b. We do not refill medications on the weekends or after hours.
   c. There is a $10.00 charge if you need the prescription sent to a different pharmacy than the one specified at your appointment.
   d. If you lose your pills you will need to wait until the next rx fill by date.
2. f you need a medication change because it isn't effective or due to side effects, you will need to follow up so that we can properly document the issues you are having.
3. All patients over 16 years of age will be **drug tested**. If you have a **positive drug test** we will no longer be able to prescribe stimulant medications for your ADD. This includes marijuana. You will be changed a non-stimulant medication.
4. DPS Screening will be done on all patients as required by state law.

I have read, understand, and agree to comply with the above policies.

Name of Patient: ___________________________________ DOB: _____________

Signature of Patient/Parent of minor:______________________________________

Parent's name if patient is a minor: ______________________________________

Patient History Form

This is a confidential record and will be kept in your doctor's office.
Information contained here will not be released to anyone without your authorization.

Allergies	Type of Reaction

Social History

Smoking	Yes No	
Alcohol	Yes No	
Street Drugs	Yes No	
Caffeine	Yes No	
Tattoos/Piercings	Yes No	
Exercise	Yes No	
Special Diet	Yes No	
Living Will	Yes No	

GR ____ PARA ____AB _____ MENARCHE ______ MENOPAUSE _____

Marital Status: ☐ SINGLE ☐ Married ☐ WIDOWED

☐ Deaf ☐ HOH ☐ Bllind ☐ VISION IMPAIRED ☐ Aids for Mobility _______

Spouse's Name: ______________________________

Occupation: _________________________

Immunizations	Dates					
Influenza						
Diphtheria/Tetanus						
Pneumonia						
PPD						

Family History

Relationship	Problems
Mother	
Father	
Maternal GP	
Paternal GP	
Siblings	
Children	

Medical History	Year

Surgical History	Year

Health Maintenance

	Date	Results	Date	Results	Date	Results	Date	Results	Date	Results
Annual Exam										
PAP										
Mammogram										
Bone Density										
EKG										
Chest X-ray										
Stress Test										
Echo										
Dopplers										
PSA										
FOBT										
Colonscope/BE										
Eye Exam										
Dental Exam										

Comments/Notes

PT NAME ______________________ DOB ________ Provider: _________________________