Medical Colleagues of Texas, LLP

Patient Information

SS#:_____ **First:** _____ **Middle Initial:** ____ **Last:** _____

Sex: ____ **DOB:** _____ **Marital Status:** ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** ☐ **Separated**

Employment Status: ☐ **Unemployed** ☐ **Retired** ☐ **Student** ☐ **Employed** **Employer:**_____

Patient Address: _____ **City:**_____ **State:**_____ **Zip:**____

Email: _____ **Home Phone:** _____ **Work Phone:** _____ **Cell:**_____

Referring Provider: _____ **How did you hear about us:** _____

Preferred Pharmacy: _____ **Phone:** _____ **Location:**_____

Emergency Contact: _____ **Relationship:**_____ **Cell:** _____ **Home:**_____ **Work:**_____

Responsible Party

Name of Person Responsible for this Account: _____ **Relationship to Patient**_____

Address (if different from patient's)**:** _____

Cell :_____ **Home Phone:**_____ **DOB**_____ **SSN:**_____

Employer: _____ **Work Phone:**_____

Have we seen other members in your family? ☐ **No** ☐ **Yes** **Name:**_____ **DOB:** _____

Insurance Information

Insured/Care Holder's Name: _____ **Relationship to Patient:**_____

DOB:_____ **SSN:**_____ **Employer:** _____

Insurance Company: _____ **Group#:** _____ **Policy/ID #:** _____

Address:_____ **Provider Ins. Verification Phone #:**_____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO (If YES, Please Complete the Following)

Name of Insured _____ **Relationship to Patient:**_____

DOB:_____ **SSN:**_____ **Employer:** _____

Insurance Company: _____ **Group#:** _____ **Policy/ID #:** _____

Address:_____ **Provider Ins. Verification Phone #:**_____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE AVAILABLE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize my insurance company to pay and hereby assign to Medical Colleagues of Texas, LLP all benefits payable for services rendered. I understand I am financially responsible to pay non-covered services.

_____
Signature (Patient or Parent if Minor) Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information required in the course of my treatment necessary to process insurance claims.

_____
Signature Date

Medical Colleagues of Texas, LLP
Acknowledgment and Consent of
Notice of Privacy Practices

I understand that **Medical Colleagues of Texas'** Notice of Privacy Practices, which explains how my medical information will be used and disclosed, is posted in the waiting room. I acknowledge that I have access to this information and understand that I am entitled to receive a copy of this document if requested.

Patient Record of Disclosures

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that communication of PHI be made by alternative means, such as leaving a message on answering machines, discussing your health information with someone other than yourself, and by communicating with you through electronic communication.

Patient Contact Numbers **May we leave a message?**

Cell #: _____ ☐ Yes ☐ No

Home #: _____ ☐ Yes ☐ No

Work #: _____ ☐ Yes ☐ No

Email Address: _____
Email to be used for Patient Portal registration purposes

Other than yourself, whom may we talk to about or leave medical information with?

Name: _____ Relationship: _____

Cell #: _____ Home #: _____ Work #: _____

Name: _____ Relationship: _____

Cell #: _____ Home #: _____ Work #: _____

Name: _____ Relationship: _____

Cell #: _____ Home #: _____ Work #: _____

By signing below, I authorize Medical Colleagues of Texas to use and disclose my medical information for the Purpose of Treatment, Payment, and Health Care Operations.

_____ _____
Signature of Patient or Authorized Representative **Date**

_____ _____
Printed Name of Patient **Patient's Date of Birth**

Financial Policy of Medical Colleagues of Texas, LLP

Thank you for placing your trust in us as your health care provider. Our primary concern is to provide you with the best medical care possible. In order to prevent misunderstanding, we ask that you read and sign our financial policy. If you have any questions or concerns about our policies, please do not hesitate to ask.

1. Our physicians are contracted with certain health plans; **it is your responsibility to make sure your particular plan is in network with your physician.** Although some insurance companies provide their members with an electronic copy of your insurance card, it is preferred that we have a hard copy of your card so that we can scan it into your account to help avoid any billing issues. If we are unable to verify your insurance prior to your appointment, you may be required to be self-pay for your visit. If you have a change in your coverage, please provide us with your new coverage information **before your visit** so that we can verify your eligibility and benefits and file your claim in a timely manner. Insurance plans have filing deadlines. We will not file claims if your insurance is provided outside of the plan's deadlines.

PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED.
WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AND PERSONAL CHECKS.

2. YOUR INSURANCE COMPANY REQUIRES COPAYS TO BE COLLECTED AT THE TIME OF YOUR VISIT. Inability to make payment at that time may require us to reschedule your visit. Deductibles, copays, coinsurance, and non-covered services must be paid at the time the service is provided.
3. Charges subject to a yearly deductible are due at the time of service. Deductibles and coinsurance amounts are determined and due prior to procedures. Any overpayment will be promptly refunded.
4. MEDICARE PATIENTS: It can be considered Medicare fraud to waive deductibles and copayments. Therefore, deductibles and copayments will be collected at the time of service.
5. MISSED APPOINTMENTS: We require at least a 24-hour notice to cancel appointments. If you cancel or miss your appointment without this advanced notice, a "missed appointment fee" of $50.00 will be charged.
6. RETURNED CHECKS will incur a $30.00 fee. The amount of the check plus the fee must be paid within 10 days of notification by credit card, cash, or money order to prevent further action. If a second check is returned on your account, we will no longer be able to accept personal checks as payment.
7. There will be a minimum of $25.00 prepayment for completion of forms such as "FMLA", disability, etc.
8. We do not accept third party insurance plans such as Worker's Comp or motor vehicle accident insurance.
9. **It is your responsibility to know and understand your insurance benefits. Ultimately, all charges are your responsibility.**

Medical Colleagues of Texas offers electronic statements and payment options. Electronic statements will be sent to a primary email address for all patients on one financial account.

Would you like to opt in to receive e-statements? ☐ **Yes** ☐ **No**

If yes, please list your preferred email:

_____

_____ _____

Signature of Patient or Authorized Representative **Date**

_____ _____

Printed Name of Patient **Patient's Date of Birth**

MCT Medical Colleagues of Texas, L.L.P.

Date: _____

Ob/Gyn Medical History

Name: _____ DOB: _____

Last Pap Smear: _____ Last Mammogram: _____

Last Menstrual Period: _____ Birth Control Method: _____

Do you think you could be pregnant? _____

Medications and Supplements: List the Names of Medications/Supplements, Doses, & Frequency Taken

_____

_____

_____

_____

Drug Allergies: List below or circle the following: **NO KNOWN DRUG ALLERGIES**

_____

PERSONAL MEDICAL HISTORY: Circle all that apply, and provide additional details or other issues below

Abnormal Pap Smear ▪ Blood Clot ▪ Breast Mass ▪ Cancer ▪ Diabetes ▪ Heart Disease

High Blood Pressure ▪ Migraines/Headaches ▪ Neurological Disease ▪ Venereal Disease ▪ Thyroid Issues

_____

_____

Surgical History: List the Surgery, Date, and Reasons/Complications

_____

_____

_____

_____

(Continued on back)

OB History, if applicable: List the Date of Delivery, Sex, Weight of Baby, and any Complications

Date: ____/____/____ _____

Date: ____/____/____ _____

Date: ____/____/____ _____

Date: ____/____/____ _____

Family Medical History: List the Disease (such as Cancer, Diabetes, Thyroid, High Blood Pressure) and your Relation (such as mom, dad, grandparent)

_____

_____

_____

_____

Social History (circle)

Tobacco: NO YES

Number of Years Smoking: _____ Quit Date: _____ Cigarettes per day: _____

Alcohol: NO YES SOCIALLY

Number of drinks a week: _____ Quit Date: _____

Drugs (marijuana, cocaine, etc.): NO YES

Name of drugs: _____ Last date of use: _____

Marital Status: Single Married Divorced Widowed

Occupation: _____

Reason for visit today:

_____

_____

_____

_____

Thank you for choosing MCT!