Little Elm Medical Clinic, PA
730 E. Eldorado Parkway
Little Elm, TX 75068

Financial Policies

Thank you for choosing Little Elm Medical Clinic. We are committed to providing quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibilities for services rendered, we have developed this financial policy. Our billing office is located in Dallas and can be reached at 972.792.5700 if you need assistance.

INSURANCE:
We participate in most insurance plans. Please bring your up-to-date insurance card with you to each visit. It is your responsibility to make sure that our providers are on your specific plan and in-network for you. If you are insured by a plan we accept, but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance coverage. If you are not insured by a plan we do business with, payment is required in full at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

PROOF OF INSURANCE:
We must obtain a copy of your driver's license and a current valid insurance card to provide proof of insurance. If your health insurance changes, please notify us before your next visit so we can make the appropriate changes to help you maximize your benefits. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

CO-PAYMENTS, CO-INSURANCE & DEDUCTIBLES:
All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients can be considered fraud. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. We accept cash, check, Visa, MasterCard and Discover.

CLAIM SUBMISSION:
We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies a claim for any reason, our office cannot be responsible for that bill. It is your responsibility as the patient to pay the denied amounts in full. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. It is your responsibility to know if our providers are in-network for your insurance plan and what your specific insurance plan's benefits are.

NON-COVERED SERVICES:
Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurance plans. Please be aware that your insurance company may require a second co-pay if you address other problems during a physical exam or at the same time you have a procedure scheduled. Concerns dealing with mental health issues such as anxiety, depression, attention deficit disorder, and stress-related problems, etc. might not be covered by your insurance. If you are seeing our doctor for any of these problems, you may want to contact you insurance company to see if they are covered if seen by any physician other than an approved mental health provider. As with all non-covered services, you will be expected to pay in full whatever the insurance companies do not reimburse.

NONPAYMENT:
If your account is over 90 days past due, you will receive a letter stating that the balance should be paid in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. Should this occur, you will be notified by certified mail and will have 30 days to find a new physician.

MISSED APPOINTMENTS:
If you cannot keep your appointment, you will need to reschedule your appointment 24 hours in advance. This will allow us to schedule another patient in that time slot. If any appointment is no-showed, cancelled with less than 24 hours notice or rescheduled due to late arrival, a $35.00 charge may be billed to your account. This charge is not payable by your insurance company. If multiple appointments are missed and we identify a problem with you keeping appointments, we will not be able to provide care for you at this office.

FORMS:
There is a $25 charge for the completion of FMLA, disability and other forms. Since insurance companies do not cover this service, this charge is your responsibility. Payment is due at the time the forms or requests are dropped off at the clinic.

PATIENT DEMOGRAPHICS

Patient Name:_____ DOB:_____ Sex: M or F

Address:_____ City:_____ State:_____ Zip Code:_____

Home phone #:_____ Mobile #:_____ Work #:_____

Email:_____

Email address is required for patient portal access.

Marital Status: _____ SS#:_____

Referred by:_____ Relationship:_____

☐ **Former Patient** ☐ **Website** ☐ **Google** ☐ **Health Fair** ☐ **Banner**

Primary Insurance:_____ **Policy Holder Name:** _____

ID#_____ Group #_____ Policy Holder DOB: _____

Secondary Insurance: _____ **Policy Holder Name**:_____

ID#:_____ Group#:_____ Policy Holder DOB:_____

Preferred Pharmacy:_____ City:_____ Phone #: _____

Pharmacy Intersection: _____

Patient Preference Regarding Communication of Health Information

Who To Contact: I hereby give my permission to Little Elm Medical Clinic to disclose and discuss information related to my medical condition(s) to/with the following persons.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

_____I do not wish to give consent for any persons to have access to any information regarding my medical condition(s).

Emergency Contact:_____ Phone #:_____ Relationship: _____

I understand that in the event of an emergency it may be necessary to give certain medical information to this contact.

This authorization shall remain in effect unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical records.

Signature of Patient or Legal Representative: _____

Printed name and relationship (if not patient):_____

Today's Date:_____

Patient Name:_____ DOB:_____

Consent to Treat

I hereby authorize employees and agents (including physicians, physician assistants, and nurse practitioners) of this medical office to render routine medical care to me, the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) I hereby authorize employees and agents of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians (including consultants, associates, and assistants of the physician's choice.) The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, medical care will not be provided except in a case of emergency.

Financial Responsibility

I hereby authorize payments from Medicare or other insurance companies of medical benefits directly to Little Elm Medical Clinic and/or the attending physician for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services. I appoint Little Elm Medical Clinic to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment. I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Little Elm Medical Clinic. I further understand that should by account become delinquent, I shall pay the reasonable fees or collection expenses, if any. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier. The duration of this authorization is indefinite and continues until revoked in writing.

Release of Information

Authorization is hereby granted to release of information contained in my medical record as may be necessary for medical treatment or to process and complete my insurance claims. I understand that this release of information may include information regarding communicable diseases such as, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). The duration of this authorization is indefinite and continues until revoked in writing.

Financial Policies

I have read and received a copy of the financial policies for Little Elm Medical Clinic.

Acknowledgement of Receipt of the Notice of Health Information Practices for Little Elm Medical Clinic

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care. Little Elm Medical Clinic and associated physicians are committed to securing the privacy of your health information. We have made available to you a copy of the notice which provides information about how its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Little Elm Medical Clinic's Notice of Health Information Practices.

I have read all of the above and agree to these terms.

_____ _____

Signature of Patient/ Legal Guardian (if patient is a minor) Date

Little Elm Medical Clinic, PA

730 E. Eldorado Parkway
Little Elm, TX 75068

AUTHORIZATION TO RETRIEVE MEDICATION RECORDS

I_____authorize Little Elm Medical Clinic to retrieve my complete medication profile from my insurance, pharmacy, or other third party source. I understand this information will be kept confidential and used only to aid in my ongoing treatment.

I understand this authorization will remain in effect until/unless I revoke it in writing.

_____
Signature of Patient (or Authorized Representative)

_____
Date

LITTLE ELM MEDICAL CLINIC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize_____
(Entity/Person from Whom Records are Requested)

_____
(Full and Complete Address)

_____
(Phone and Fax Number, if available)

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name _____

Date of Birth ☐☐/☐☐/☐☐☐☐ (MM MM DD DD YY YY YY YY) Social Security Number ☐☐☐-☐☐-☐☐☐☐

Patient Address_____Phone Number (____)_____- _____

Date(s) of Service (if known) _____

Description of information to be released: (Check ✓ all that apply)

____Emergency Room	____Radiology Reports	____Admission / Registration	____Other: _____
____History & Physical	____Consultation Reports	Records	_____
____Nurse's Notes	____Physician's Orders	____Laboratory Reports	_____
____Progress Notes	____Operative Records	____Billing Records	_____
____Discharge Summary	____Radiology Films	____Medication List	

Description of the purpose of the use and / or disclosure: _____

_____

The health information described herein shall be released to:

LITTLE ELM MEDICAL CLINIC
730 E. ELDORADO PARKWAY
LITTLE ELM, TX 75068
PHONE: (972) 292-3330 FAX (972) 292-3332

☐ **DR JOHN FLORES**
☐ **DR JILL WOLF**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed below. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

Printed Name of Patient's Representative:_____ Relationship:_____

MEDICAL HISTORY

NAME _____ **DATE OF BIRTH** _____

Have you ever been treated for any of the following medical problems? (please circle)

High Blood Pressure	Diabetes	Depression
Heart Disease	Thyroid Disorders	Anemia
High Cholesterol	Liver Disease	Cancer
Lung Disease	Kidney Disorders	Muscular Disorders
Stomach/Intestinal Disorders	Nerve Disorders	Other

Have you ever received any blood transfusions? Yes No **What Year(s)** _____

Preferred Pharmacy Name _____ **Location** _____
Pharmacy Phone Number _____

Current Medications (list all please)

Name	Dose	Directions of Use

Drug Allergies

Name of Medication	Reaction(s)

Hospitalizations/Surgeries (list all please)

Procedure	Date	Procedure	Date

Have any of your blood relatives been diagnosed or treated for any of the following?

Colon Cancer	Prostate Cancer	Breast Cancer
High Blood Pressure	Diabetes	Heart Disease
Thyroid Disorders	Bleeding Disorders	High Cholesterol
Stroke	Seizures	Leukemia

Social History

Martial Status **(circle one)** M S D W Live with significant other

Do you use tobacco now? Yes No How Much? _____ How Long? _____
Have you used tobacco in the past? Yes No When did you quit? _____
Do you use alcoholic beverages? Yes No Type and Weekly Amount _____
Have you ever used illicit drugs? Yes No Type and Amount _____

Immunizations

Date of Last Tetanus _____ Pneumonia _____
Influenza _____ Hepatitis B series _____

Patient Name_____DOB_____Today's Date_____

REVIEW OF SYSTEMS

CONSTITUTIONAL

- ☐ Weight Changes
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weakness
- ☐ Change in Appetite

SKIN & INTEGUMENTARY

- ☐ Rashes
- ☐ Lesions
- ☐ Mole Changes
- ☐ Itching

EYES

- ☐ Visual Changes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Pain

RESPIRATORY

- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

EARS, NOSE, THROAT

- ☐ Headache
- ☐ Hearing loss
- ☐ Ear Pain
- ☐ Ringing in Ears
- ☐ Nasal Congestion
- ☐ Nasal Discharge
- ☐ Sinus Pain
- ☐ Swollen Glands
- ☐ Sore Throat
- ☐ Snoring
- ☐ Difficulty Swallowing

ENDOCRINE

- ☐ Heat Intolerant
- ☐ Cold Intolerant
- ☐ Excessive Thirst

PATIENT SIGNATURE:

CARDIOVASCULAR

- ☐ Chest pain or Pressure
- ☐ Irregular/Skipped Beats
- ☐ Shortness of Breath
- ☐ Swelling of Feet
- ☐ Varicose Veins
- ☐ Feel Heart Beating
- ☐ Painful Calves

GENITOURINARY

- ☐ Frequency
- ☐ Urgency
- ☐ Painful Urination
- ☐ Urinating at Night
- ☐ Weak Stream
- ☐ Blood in Urine
- ☐ Genital Lesions
- ☐ Discharge

MUSCULOSKELETAL

- ☐ Joint pain or Swelling
- ☐ Restricted Motion
- ☐ Muscle Pain
- ☐ Back Pain

NEUROLOGICAL

- ☐ Fainting
- ☐ Confusion
- ☐ Seizure
- ☐ Tremors/Shakiness
- ☐ Speech Difficulty
- ☐ Paralysis
- ☐ Numbness
- ☐ Tingling

MENTAL HEALTH

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Crying Spells

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Rectal Pain
- ☐ Rectal Bleeding
- ☐ Excessive Gas
- ☐ Bloating
- ☐ Excessive Belching
- ☐ Heartburn

HEMATOLOGIC/LYMPH

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymph node enlargement/tenderness
- ☐ Hepatitis or Jaundice in the past

WOMENS HEALTH

- ☐ Breast Lump/Changes/Pain
- ☐ Nipple Discharge
- ☐ Abnormal Vaginal Discharge
- ☐ Dryness
- ☐ Vaginal Itching
- ☐ Abnormal/Painful Periods
- ☐ Pelvic Pain
- ☐ Hot Flashes
- ☐ Difficulty/Painful Sex

Other Symptoms:

If you have an active problem today that needs to be addressed, your preventative exam will be rescheduled.