MD TruCare PA

823 Ira E Woods Ave Suite 200 Grapevine TX 76051

Ph: 817-722-6078

			Date:
PATIENT INFORMATION			
Last Name:	First Name:	Middle:	SS#
Email Address:	Birthdate: ()	Age:	Marital Status: Single/Mar/Div/Sep/Wid
Street Address:	City:	State:	ZIP Code:
Home Phone: ( ) May we leave message on your voice mail? _____Yes _____No	Cell Phone: ( ) May we leave message on your voice mail? _____Yes _____No	Work Phone: ( ) May we leave message on your voice mail? _____Yes _____No	
Pharmacy:	Address:	Phone:	
Employer Name:	Occupation:		
PHYSICIAN INFORMATION			
Primary Care Physician:	Phone: ( )		
Referring Physician:	Phone: ( )		
EMERGENCY CONTACT INFORMATION			
Emergency Contact:	Phone: ( )		
Spouse/ Significant Other Name:	Phone: ( )		
INSURANCE INFORMATION			
Primary Insurance Name:	Member ID#	GRP#	
Insurance Address:	Phone: ( )		
Policy Holder's Name:	Birthdate	Policy Holder's SS#	
Secondary Insurance Name:	Member ID#	GRP#	

MD TruCare PA
PRIVACY NOTICE
FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

1. The Privacy Notice includes a complete description of the use and /or disclosures of my personal health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: Telephoning my home and leaving a message on my answering machine or with the individual answering the phone and text messages.

4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, it is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

9. The privacy Notice of MD TruCare PA (the "practice") has been provided to me prior to signing this consent. The practice has explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Patient (Printed) Signature of Patient or Legal Guardian Date

FINANCIAL POLICY

Co-payments and Deductibles All co-payments and deductibles will be collected on the day of your appointment, as you check in. All Insurance companies require that physician collect all co-pays/ deductibles from the patient at the time of service. The arrangement is also part of your contract with your insurance company. We accept payment in the form of cash, check, debit or credit card. If you are unable to pay your co-pay, the office of MD TruCare will hold the right to postpone future office visits, until outstanding balances are paid.

Insurance We are contracted providers for most insurance plans. If you are insured by a plan we do business with, payment in full is mandatory at each visit. If you are insured by a plan we do business with, but don't have up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance coverage should change, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

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. It is your responsibility to comply with their request. Please be aware that the balance for your claim is your responsibility whether or not your insurance company pays for you claim. If your insurance company does not pay your claim after 120 days after your date of service, the balance will automatically be billed to you.

Non-Payment If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you will be discharged from this practice.

As acknowledged by my signature below, I understand the payment policies of MD TruCare and I also understand that I am financially responsible for all charges incurred regardless of insurance coverage. If the balance on my account is not paid, I agree to bear all interest charges and collection costs. I also authorize the release of limited medical information to my insurance company, as required for payment of charges and authorised payment of insurance benefits directly to MD TruCare for all services rendered.

_____ _____

Patient Signature Date

MEDICATION RELILLS POLICY

The following policies are designed to improve the efficiency of the office and communication between you and the staff of MD TruCare. Please **read, initial each statement** and **sign** at the bottom of the page to indicate your understanding of the policies.

It is your responsibility to **fill your prescription before you run out of medications**, and to protect your medications and controlled substances as carefully as you would your money or jewellery. There will be no refills of stimulant or benzodiazepine medication prior to the appropriate time. **This is usually about 3 days prior to the next scheduled refill date. _____ (initial)**

Prescriptions for controlled medications constitute an even more burdensome medico-legal and administrative responsibility. I do not prescribe addiction medications (medication with high abuse potential) for patients with a history of substance abuse, particularly those that the patient has already abused. Also, **we do not refill lost, misplaced, stolen or otherwise unavailable addicting medication** except under very special circumstances, and even then, we make only one exception. **It is your responsibility to fill your prescription before it expires**. _____ **(initial)**

Reasons such as:

1. "I went up on the dose on my own."
2. "I went out of town and left my medication behind when I returned home."
3. "The airlines lost my luggage which contained my medications."
4. "My spouse/roommate/girl or boy/friend/son/daughter/pet etc... stole my medication."
5. "I gave a few pills to my spouse/significant other ..... because he or she needed them."
6. "I opened my medication above the sink/ toilet/ pool/ lake..... and it fell in."

are **Not** valid reasons for early refills of medication, so please do not ask. _____ **(initial)**

Refill of prescriptions require periodic office visits with the doctor. It is important to comply with your schedule doctor's visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Schedule visits must be followed in order for the prescription(s) to be filled. _____ **(initial)**

Thank you for your anticipated cooperation.

I understand and will comply with these policies. _____ **(initial)**

_____

Patient Signature or Parent/Guardian Date: _____

_____

Printed Name

MD TruCare PA
823 Ira E. Woods Ste 200
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No Show Policy Acknowledgement Form & other fees not covered by insurance

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINMENT

I understand and agree to the following terms:

1. It is my responsibility to notify MD TruCare PA if I need to cancel of reschedule a schedule appointment no less than 24 hours prior to the schedule appointment.

2. I hereby agree that I will be billed by my provider **$50** in the event that I miss an appointment.

3. Fees for requested Medical Records are **$25** for the first 50 pages, anything over that or thereafter will be $**.50 cents per page. Please call at least 24 hours in advance so the documents can be prepared for you.**

4. Fee for a letter to University, Employers, Etc is **$30 for the first two pages and $50 for more than two pages.**

5. Telephone calls (Consultation) **$30** for 15 minutes

6. There will also be a **$20** charge for some non-office visit refills of **Schedule II Controlled Substance (ex. Adderrall)** when you are calling in for a refill. This payment **must** be obtained before sending out your prescription and this can be done via phone, email, or in person.

7. Please note that there will be a fee of **$50** for any receipt of a bounced check as the bank takes a processing fee.

8. **I understand that these fees are non-covered services and may not be billed to my insurance carrier**.

_____ _____

Acknowledgement by Patient (Signature) Date

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823 Ira E. Woods Ste. 200
Grapevine, TX 76051

Disability/ FMLA Paperwork Consent

Effective immediately as per our policy. Any new patient requests for Disability/ FMLA paperwork require that patient will be seen at the clinic at least 3-4 times over a period of six months. Upon completion of this frame, it is under the provider's discretion to determine if the patient qualifies for disability regarding psychiatric conditions. This does not guarantee that the patient's employer will approve the claim of payment for the time off of work. All disability/ FMLA paperwork is billed to the patient directly for $150. It is not billed to the patient's insurance. Payment must be received before the paperwork is filled out.

Thank you for your cooperation.

_____ _____

Acknowledgement by Patient (Signature) Date