Stinnett Medical Clinic

711 S. Stewart Stinnett, TX 79083
(806) 878-2271 Fax (806) 878-2272

PATIENT INFORMATION

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Race _____ Ethnicity: _____ Sex: Female / Male Marital Status: S M W D

Mailing Address _____ City _____ State_____ Zip_____

Physical Address_____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Patient Employer_____ Phone # _____ Occupation _____

Emergency Contact Name_____ Emergency Contact Phone # _____

Personal Physician_____ Referred by Dr. _____ Dental Provider: Dr._____

RESPONSIBLE PARTY / BILLING INFORMATION ☐ *Same as PATIENT information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

INSURANCE INFORMATION Do you have Insurance? [ ] Yes [ ] No Is this an on the job injury? [ ] Yes [ ] No Date of injury? _____

*You must provide our office with a current Insurance card.

1) Insurance Carrier Name_____ 2) Insurance Carrier Name_____

INSURED / POLICY HOLDER INFORMATION ☐ *Same as PATIENT information* ☐ *Same as RESPONSIBLE PARTY information*

First Name_____ MI ____ Last Name_____ Date of Birth _____

Age: _____ Social Security # _____ Sex: Female / Male Relation to Patient:_____

Mailing Address _____ City _____ State_____ Zip_____

Home Phone # _____ Cell Phone # _____

Employer_____ Phone # _____ Occupation_____

AUTHORIZATIONS AND ACKNOWLEDGEMENT

Do you have an advanced directive? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Do you have a Durable Power of Attorney for Healthcare? [ ] Yes [ ] No If so we will need a copy for your file. Copy provided [ ] Yes [ ] No

Is Stinnett Medical Clinic you Medical Home? [ ] Yes [ ] No

The **medical home** also known as the patient-centered medical home (PCMH), is a team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. It is "an approach to providing comprehensive primary care for children, youth and adults

I voluntarily request that Stinnett Medical Clinic and such assistants as they may deem necessary, manage/treat my condition and I hereby release Stinnett Medical Clinic, Golden Plains Community Hospital and any other participating health care providers from any and all liability. The duration of this consent is identified and continues until revoked in writing.

BENEFITS TO PHYSICIAN: I hereby authorize the release of information relating to all claims for referral and benefits submitted on behalf of myself and/or dependents I hereby authorize payments directly to Golden Plains Community Hospital and/or the health care provider of the medical and/or surgical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

I understand all of the above and hereby state that the information is correct to the best of my knowledge. My signature indicated that I have read the above and grant the request of authorizations.

X_____ _____ _____

Signature of Patient or legal guardian **Printed Name** **Date**

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PATIENT HISTORY FORM

NAME: _____ **Date** ____/____/____

D.O.B. ____/__/____ **Age** _____ **PREFERRED PHARMACY:** _____

A. REVIEW OF SYSTEMS

YES	NO	GENERAL
		1. Unexplained weight loss more than 10 lbs. in the past year?
		2. Night sweats
CARDIO-RESPIRATORY		
YES	**NO**	
		3. Hypertension (high blood pressure)
		5. Chest Pain
		6. Blood Clots
		7. Swelling of legs or feet
		9. Shortness of breath
GASTROINTESTINAL		
YES	**NO**	
		11. Constipation
		12. Diarrhea
		13. Blood in stools
		14. Liver Problems
		15. Gallbladder Problems
		16. Trouble Swallowing
MUSCULOSKELETAL		
YES	**NO**	
		22. Swollen or painful joints / Where? _____
		23. Osteoporosis
		24. Gout
SKIN		
YES	**NO**	
		25. Acne
		26. Rash
NEUROLOGICAL		
YES	**NO**	
		27. Headache
		28. Seizures
		29. Dizziness
PHYCHOLOGICAL		
YES	**NO**	
		30. Depression / Anxiety
		31. Bipolar Disorder
YES	**NO**	**ENDOCRINE**
		30. Thyroid problems
		31. Diabetes
YES	**NO**	**PREVENTATIVE**
		32. Colonoscopy after age 50? Date: _____
		33. Mammogram after age 40? Date_____
HEMATOLOGICAL / LYMPHATIC		
YES	**NO**	
		34. Anemia
		35. Blood clotting disorder

ALLERGY *(please list)*

1.
2.
3.
4.

B. Obstetrical History

(please list **ALL** pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) and abortions

Year	M / F	Wt.	Type of Delivery	Length of pregnancy	Problems	Age

GYN HISTORY (Check ALL that apply)

Age of first Period? _____ | Last Menstrual period? _____

Cycle length every _____ days | Lasting _____ days

Periods are: ❑Regular ❑Irregular ❑Painful ❑not bothersome | Flow is: ❑Light ❑Light to moderate ❑Moderate to heavy ❑Very Heavy

Date of last PAP Smear _____ ❑Normal ❑ Abnormal

METHOD OF BIRTH CONTROL

❑	Condoms	❑	Pills	❑	Patch	❑	Vaginal Ring
❑	Tubal	❑	Essure	❑	IUD	❑	Other
❑	Partner with Vasectomy			❑	Natural family planning		

SEXUAL HISTORY

YES	NO	
		Are you sexually active?
		Virginal?
		New partners?

Number of lifetime partners? _____

Sexual preference?

❑	Heterosexual (Opposite sex)	❑	Same Sex	❑	Bi-sexual

MEDICATION LIST

1.
2.
3.
4.
5.

HOSPITALIZATION AND SURGERIES

Year	Reason

COMMENTS:

CONTINUED NEXT PAGE

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PATIENT HISTORY FORM (CONT'D)

NAME: _____ **Date** ____/____/____

D.O.B. ____/__/____ **Age** _____ **PREFERRED PHARMACY:** _____

C. FAMILY HISTORY					
Are you adopted? ☐Yes ☐ No					
Have your biological (parents, brothers, sister) had any of the following?					
YES	**NO**	**Diagnosis**	**Relative**		
		Heart disease/ heart attack/stroke before age 50			
		High blood cholesterol			
		Genetic problems			
		Cancer What Type?			
		Diabetes			
		Osteoporosis			
		Blood Clots			
Race					
Ethnicity					
Preferred Language					
D. SOCIAL HISTORY					
ALCOHOL HISTORY: ☐Current ☐ Former *Type* _____ ☐ None			**EDUCATION**	High School / College	Year
Per Day #_____ Years Used_____ Years Quit_____					
SMOKING HISTORY: ☐Current ☐ Former *Type* _____ ☐ None					
Per Day #_____ Years Used_____ Years Quit_____					
EXPOSURE TO SECOND HAND SMOKE ☐ YES ☐ NO					
☐ In the home ☐ Other:					
DRUG USE: ☐Current ☐ Former *Type* _____ ☐ None					
Per Day #_____ Years Used_____ Years Quit_____					
IMMUNIZATIONS (Check the ones you have received)			**Does not receive**	Verified by :	Year
❑ Flu Vaccine				❑Verbal ❑Record ❑Immtrac	
❑ Pneumococcal				❑Verbal ❑Record ❑Immtrac	
❑ Varicella (chicken pox)				❑Verbal ❑Record ❑Immtrac	
❑ Zostavax (shingles)				❑Verbal ❑Record ❑Immtrac	
❑ T-dap				❑Verbal ❑Record ❑Immtrac	
❑ Other				❑Verbal ❑Record ❑Immtrac	
❑ Other				❑Verbal ❑Record ❑Immtrac	

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Welcome to our practice!

We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO and HMO networks. However due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. Therefore it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before an appointment. You will be responsible for payment in full for services rendered by a physician if he/she is not in your plan.

YOU MUST PRESENT A VALID ID CARD AND INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

REFERRALS

It is ***your*** responsibility to obtain from your primary care physician referrals required by your insurance company to see a specialist, as well as to track the number of your visits and keep your referrals current. Without a current referral at the time of the visit, your appointment will have to be rescheduled.

CO-PAYMENTS

We are required to collect your co-payment at the time of service. If the co-pay amount is not listed on your card, or you have a standard traditional plan, we will collect the percentage of the services rendered that is applicable to your plan.

NON-MANAGED CARE

For non-managed care of traditional plans, we will file a claim as a courtesy. However, the contract with your insurance company is between you and this company. We are not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days payment is not relieved by your insurance company, payment will be due by you, regardless of the status of your claim.

DEDUCTIBLE

If you have a deductible, and it is likely that the services rendered will go toward your deductible, payment in full must be made at the time of service. Unless other arrangements have been made with our office

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Pre-certification of hospital admissions and other special services is an area in which we strive to help. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform this office when pre-certification is a requirement of your plan. Due to the varying policy provisions of all the different plans, it is impossible for us to know each patient's specific plan provisions. If you fail to disclose pre-certification requirements PRIOR to services being rendered, you will be responsible for payment of all related fees in full.

FOR ALL SERVICES PROVIDED OUTSIDE OF OUR OFFICE, YOU MUST BE AWARE OF; AND INFORM US, WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN. THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC, AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file secondary insurance as a courtesy for you. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment of your account if we are unsuccessful in obtaining reimbursement by your insurance.

RESPONSIBLE PARTY (GUARANTOR)

The guarantor of the account is the patient who comes in for treatment or the adult who brings in the minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings in the minor child, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of our office to become involved in medical bill disputes resulting from divorce, etc.

LIABILITY OR AUTO ACCIDENT CLAIMS

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to file your claim.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. Please notify us if you need this service.

NSF CHECKS

Once a check is returned for NSF, we will accept only cash or money orders for future visits.

NON-PAYMENT OF ACCOUNTS / NON-COMPLIANCE

Accounts for which we are unable to collect, the balance will be discharged. Our physicians /providers reserve the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood, and agrees to the policy of this office.

X_____ _____

Signature of patient or legal guardian **Date**

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ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that **Golden Plains Community Hospital** provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature	Date
Personal Representative Signature (if applicable)	Relationship to Patient

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Permission to Disclose Information
To those involved in my care

Patient Name: _____ DOB: _____

I hereby allow STINNETT MEDICAL CLINIC to disclose the following information to the people listed below.

(Please give full name)

- ❑ Spouse: _____
- ❑ Family friend(s): _____
- ❑ Children: _____
- ❑ Others: _____

_____

In the following forms of communications

- ❑ Home Telephone
- ❑ Work Telephone
- ❑ Home voice messaging system
- ❑ Work voice messaging system
- ❑ Cellular phone
- ❑ Cellular voice messaging system
- ❑ Other: _____
- ❑ All of the above

• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department. Revocation will not apply to information that has already been disclosed in response to this authorization.

_____ _____
Patient / Guardian Signature Date:

_____ _____
Witness Date: