Physicians have always protected the confidentiality of our patient's personal health information (PHI) by securing medical records away from open access and refusing to reveal information. Additionally, state and federal laws also set security standards to ensure confidentiality of this sensitive information. The federal government has published regulations known as the "Privacy Rule", which protect health information that is maintained by physicians, hospitals, and other health care providers and health plans.

These new regulations protect virtually all patients regardless of where they live or receive health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital and any other health care provider must comply with the "Privacy Rule". All health information including written, oral, or electronic is protected.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions. We also take precautions in our office to safeguard your PHI, such as training our employees and employing computer safety measures.

In the reception room, we have placed several copies of our "NOTICE OF PRIVACY PRACTICES". This notice contains details on how your PHI is handled by our office and how you can exercise your rights with regards to your health records. You may request, from the receptionist, a copy of the "NOTICE OF PRIVACY PRACTICES" to take with you for further review.

Federal regulations require that we document that the patient has been advised of our privacy practices and offered a copy of the notice. We must also receive documentation of the patient's authorization for communication. We require that you complete the attached form to serve as the formal documentation for both notice and consent for communication. If you have any questions regarding out privacy practices you may schedule a meeting with our privacy officer for further detail and review.

Thank you for your patience and assistance.

2309 W. Green Oaks Blvd. • Arlington, Texas 76016 • Office (817) 496-4957 • Fax (817) 496-3783

Informed Consent-Acceptance of Liability Waiver/ Insurance Filing

There are many health insurance plans available to employers and individuals. All plans are not equal. There can be significant variances on services covered, deductibles, co-pay requirements, network requirements, pre-authorization for services, and other requirements of the policy. It is the **insured's responsibility** to verify that the services requested and the physicians are covered by the terms of your insurance plan. If there are any questions the insured is to call his/her insurance carrier to confirm coverage.

We will bill the insurance carrier in the patient's behalf. If any services are denied as out of network, not covered by the terms of the policy, policy not in force, not medically necessary, or deductible/co-pay issues, the patient or responsible party will be billed.

I have been advised of the billing protocol of Lake Arlington Family Medicine. I recognize and accept responsibility for payment should the services provided by my physician be excluded or not covered by my insurance plan.

______________________________ ________________

PATIENT SIGNATURE **DATE**

The information requested on this form is necessary to comply with Federal Regulations, to properly establish the medical record, and for filing insurance claims. It is important that all information is complete. Thank you.

Patient Last Name	**First**	**MI**	**Social Security #**	
			- -	
Date of Birth	**Sex**	**Marital Status**	**Student Status**	**Employment**
/ /	M F	M S D W Other	Full Part Not a student	Full Part Self RET military Other
Mailing Address		**City**	**State**	**ZIP**

Primary Phone # ______________________ **Secondary Phone #** ______________________

How did you hear about Lake Arlington Family Medicine?

Drive-by/Sign Family/Friend Insurance Provider Other:____________

Authorization to Release Information

I authorize Lake Arlington Family Medicine to release all medical information necessary to process claims for payment of services provided by The Physician's Clinic, P.A.

____

PATIENT SIGNATURE **DATE**

Assignment of Benefits

I assign and authorize payment of all medical benefits, commercial insurance, workers comp, and government agencies directly to Lake Arlington Family Medicine.

____

PATIENT SIGNATURE **DATE**

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Furthermore, by my specific **initials**, I authorize my physician and his/her staff, to contact me by the designated means noted below.

_______ Home Phone

_______ Home Answering Machine/Voice Mail

_______ Office/Work Place, Voice Mail

_______ Cell Phone/Voice Mail

Additionally, by my initials, I authorize my physician and his/her staff, to communicate information regarding appointments, medical results and billing issues to:

_______ Spouse ____

_______ Others ____

____

____

This Authorization shall remain in force until revoked in writing, Attention of Privacy Officer

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative (print)

____
Description of Personal Representative's Authority

Lake Arlington Family Medicine

Missed Appointments and Late Arrivals Policy

The physician and staff of Lake Arlington Family Medicine make significant effort to assure that we respect our patient's time and maintain a reasonable appointment schedule. We avoid overbooking of patient appointments and schedule the appropriate amount of time to manage the patient's designated condition.

Because we do limit the number of appointments, it is important that all patients commit to keeping their appointments as scheduled. A missed appointment may prevent a sick patient from obtaining immediate care.

All patients that are unable to maintain a scheduled appointment are instructed to call Lake Arlington Family Medicine 24 hours in advance to notify of the reschedule or cancel the appointment. Failure to notify the physician's office within the 24 hour period will result in a NO SHOW fee of $25. This fee will not be billed to the insurance carrier and is the patient responsibility.

Patients that miss 3 or more appointments without notice will be subject to termination from the practice.

Patients that arrive 15 minutes or more past their scheduled appointment time may be required to reschedule their appointment or may be seen as a work in appointment. Patients that have arrived as scheduled will be seen with priority. If the schedule is full and conditions do not allow for work in, the late arrival may be asked to reschedule on a different date.

We do appreciate your assistance in maintaining an accurate appointment schedule and will continue to do our best to honor your time.

I have read, understand, and agree to this Missed Appointments and Late Arrivals Policy.

______________________________ ______________________

Printed Patient Name Date

____

Patient/Representative Signature

Welcome to Lake Arlington Family Medicine!

To better serve you we have incorporated a new Electronic Medical Record.
We need the following information to update your electronic chart.

Name: ______________________________ Date of Birth: ____________________

Current address: ____

Cell Phone: ____

Email: ____

Major events/hospitalizations/surgeries: ____________________________________

____

____

Allergies: ____

Family Medical history: ____

____

Preventive care (Last physical/Stress Test/Colonoscopy/Etc.) ___________________

____

Social History (Work, Married?, Alcohol/Smoking/Drugs?) ______________________

____

Nutrition/Developmental history (Children Only) ____________________________

Medical Issues and diagnosis date (Hypertension 4/09, Diabetes 3/12, High Cholesterol, Thyroid, Stroke, Cancers, Etc.)

____

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____

____

Medications, Dosage, Frequency(ie. Lisinopril 10mg daily)

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