Preferred Name _____ Today's Date _____

*Patient's Name _____

First Middle Last

*Date of Birth_____ SS#_____ * Gender: ☐ M ☐ F

*Mobile Phone #_____ Home Phone # _____

*Address_____Apt / #_____

City_____ State_____ Zip _____

Email _____

Employer _____ Work Phone #_____

Who can we thank you for referring you to us?_____

Pharmacy of choice &location:_____

Other previous or current doctors:_____

Emergency Contact Information

*Contact Name_____ Relationship _____

Mobile Phone #_____ Other Phone # _____

Additional Contact Information (other than those listed above)

For patients under 18, please list all parents/guardians. Access to patient Information is to be indicated on HIPAA.

1. *Name: _____ Phone # _____
   Relationship to patient: ◯ Mother/step-Mother ◯ Father/step-Father ◯ Guardian ◯ Grandparent
   ◯ Spouse ◯ Significant other ◯ Friend ◯ Daughter/son ◯ Other _____

2. Name: _____ Phone # _____
   Relationship to patient: ◯ Mother/step-Mother ◯ Father/step-Father ◯ Guardian ◯ Grandparent
   ◯ Spouse ◯ Significant other ◯ Friend ◯ Daughter/son ◯ Other _____

3. Name: _____ Phone # _____
   Relationship to patient: ◯ Mother/step-Mother ◯ Father/step-Father ◯ Guardian ◯ Grandparent
   ◯ Spouse ◯ Significant other ◯ Friend ◯ Daughter/son ◯ Other _____

*Guarantor

Indicate the person responsible for the bill, not covered by Insurance. Insurance information is listed on a separate sheet.

☐ Self – I am responsible for any and all charges and bills associated with my medical care.

☐ Other: Name _____ DOB_____ Relationship _____

***Billing Address** (please list if different from address above): ☐ Same as above

Address_____Apt / #_____

City_____ State_____ Zip _____

*Indicates a required field

Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

CHILD'S NAME:_____ **DATE OF BIRTH:**_____

PERSON COMPLETING FORM/RELATIONSHIP_____

DATE OF FORM COMPLETION_____

MEDICATIONS:

Medication Dose How many times a day

_____

_____

_____

_____

MEDICATION ALLERGIES: □ No □ Yes

If yes, to what medication(s) and what was the reaction_____

IMMUNIZATION HISTORY:

To the best of my knowledge, my child is up to date on his/her immunizations □ No □ Yes

If no, why?_____

BIRTH HISTORY:

Please indicate any medical problems during pregnancy _____

Please list any medications taken during the pregnancy_____

Any drug or alcohol use during the pregnancy □No □ Yes _____

Delivered by □ elective C-section □ emergent C-section □ forceps □ vacuum extraction
□ normal vaginal delivery

If not a normal vaginal delivery, why?_____

Number of weeks gestation_____

Birth weight_____ APGAR scores: 1 minute_____ 5 minute_____ Discharge weight_____

Did the baby receive the Hepatitis B vaccine □ No □ Yes If yes, date given _____

Please indicate any medical problems during the newborn period_____

Name of hospital where infant was born_____

PERSONAL MEDICAL HISTORY:

Please check if your child has had any of the following medical problems:

□ ADD/ADHD	□ Chicken pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing problems	□ Recurrent ear infections
□ Anemia	□ Diabetes	□ Heart murmur	□ Seizures
□ Asthma	□ Eczema	□ Congenital heart disease	□ Urinary Tract Infections
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Vesicoureteral reflux
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

HOSPITALIZATIONS:

Has your child every stayed overnight in a hospital? □ No □ Yes

If yes, when and why?_____

SURGICAL HISTORY:

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____

_____

GYN HISTORY:

Age of first period_____years First day of last period_____ Has not had menses yet_____

FAMILY HISTORY:

Please indicate if your child has a family history (**parents, siblings, grandparents, aunts, uncles or cousins <u>to the child</u>**) of any of the following:

Diagnosis	Family Member	Diagnosis	Family Member
□ ADD/ADHD		□ Hearing disability	
□ Alcohol/Drug Abuse		□ High cholesterol	
□ Allergies		□ High blood pressure	
□ Asthma		□ HIV/AIDS	
□ Birth defects		□ Learning disability	
□ Blood disorders		□ Mental illness	
□ Cancer, type		□ Mental retardation	
□ Heart disease (heart attack, bypass, stents)		□ Migraines	
□ Deafness/Hearing problems		□ Scoliosis	
□ Depression		□ Seizure disorder	
□ Developmental delay		□ Speech problems	
□ Diabetes		□ TB/Lung disease	
□ Genetic disorder		□ Stroke	
□ Hepatitis/Liver disease		□ Thyroid disease	
		□ Other	

SOCIAL HISTORY:

Who lives at home?

Name	Relationship	DOB

Is the child cared for by any one other than the parents? □No □ Yes

If yes, by whom and how frequently?_____

Does anyone in your home smoke? □ No □ Yes

_____

Provider_____ Date_____

HIPAA – Authorization and Access of Health Information and Records

Patient's Name _____ DOB _____

Some of our patients would like us to share medical information (lab results, appointment times, etc.) with a spouse, family member, close friend, etc. However, **due to HIPAA privacy laws we are not allowed to give out any medical information without the patient's written consent.** Please list anyone you authorize Abundant Life Family Practice Staff to communicate with about your medical records.
I hereby authorize the following individuals (ex. family member or spouse, close friend) access to my personal medical records; including reports on lab, imaging, and procedures and make or cancel appointments for me. I understand I may revoke this authorization at any time and must communicate this to my doctor.

Name	**Relationship to Patient**	**Contact Phone Number**

For patients under 18 years old: The following person(s) may **NOT** bring the patient to their appointment

_____

Outstanding Balances

I understand that I am ultimately responsible for any outstanding balance left on my account. Any remaining amount not covered by my insurance (if applicable) is my responsibility. If in the event that insurance has already paid their part, it has been **over 90 days** and full payment has not been received by BCS Abundant Life Family Practice, P.A. on my account, I authorize BCS Abundant Life Family Practice, P.A. and its associates to run my credit card for the outstanding balance amount. I understand that my credit card will only be charged in the event that payment has not been received on any outstanding balance over 90 days old. If I feel like there has been an insurance error, I will contact BCS Abundant Life Family Practice, P.A. and its associates within 90 days of the date of service to correct the error.
If for some reason the insurance does remit payment on a charge they previously denied, and I have paid out of pocket for that expense, I understand that BCS Abundant Life Family Practice, P.A. will reimburse me for that payment.

Name of Card Holder: _____

Circle One: Mastercard Visa American Express Discover Other _____

Credit Card #: _____ Expiration Date: _____

_____ _____

Patient / Parent or Guardian's Signature **Date**

Payment Information, Assignment of Insurance and Authorization to Release Information

Patient's Name:_____ DOB _____

Method of payment: ☐ CASH Pay or ☐ Insurance

***Primary** Insurance Company_____ Effective Date_____

Insurance Plan Name _____ Co-Pay $_____

Type of Insurance: ☐ PPO ☐ HMO ☐ Medicaid ☐ Tricare ☐ Medicare ☐ HRA

☐ Other_____

Guarantor Name _____ Guarantor's Date of Birth _____

Name on the card

Guarantor's Relationship to the patient: ☐ Self ☐Parent ☐Spouse ☐Other _____

Member Number_____ Group Number _____

Pre-authorization Insurance Phone # _____

On the back of the card

Insurance Address_____

(Claims Address) Street address City, State Zip

Secondary Insurance Company_____ Effective Date_____

Insurance Plan Name _____ Co-Pay $_____

Type of Insurance: ☐ PPO ☐ HMO ☐ Medicaid ☐ Tricare ☐ Medicare-Supplement

☐ Other_____

I hereby authorize the above insurance company to pay directly to BCS Abundant Life Family Practice, P.A. benefits due me, if any, by reasons of services described in the statement rendered and are provided for in the above policy contract with aforementioned insurance company. I will be responsible for all such charges incurred or for all charges in excess of whatever sum may be paid by the insurance company above mentioned. I authorize the release of any medical information necessary to process this claim. I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to BCS Abundant Life Family Practice, P.A. I understand that even though I have assigned benefits to be paid directly to BCS Abundant Life Family Practice, P.A., **I am ultimately responsible for the entire bill.**

Medicare Patients certification and authorization to release information and payment request:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to BCS Abundant Life Family Practice; P.A. for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Acknowledgement of Billing and Insurance Guidelines

I have received and read the patient billing and insurance guidelines. I understand that I must pay my co-pay or the office visit fee, and any outstanding balances **prior** to seeing the doctor. It is my responsibility to give 24 hours notice before canceling an appointment, and repeatedly missed or cancelled appointments will result in my termination as a patient. I authorize BCS Abundant Life Family Practice, P.A. and its employees to contact me through any medium listed above.

_____ _____

Patient or Parent/Guardian's Signature **Today's Date**

HIPAA Notice of Privacy Practices

Please sign the back page

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. SO, PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Dept. of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

This notice was published and becomes effective on/or before April 14, 2003.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request even if you have agreed to accept this notice alternatively. (i.e. electronically)

You may have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name: _____

Signature: _____

This notice was published and becomes effective on/or before April 14, 2003.

This copy is for you to keep

BCS Abundant Life Family Practice, P.A. - Russell Bacak, M.D.

Policies and Practice Information and Guidelines

The following is a guide to help patients understand some of the more complicated aspects of medical billing and health insurance. We understand that health insurance plans can be difficult and if you have any questions or concerns, please ask. We use a billing company, Marway, which deals directly with the insurance companies.
For billing questions, Stacy or Julie can be contacted at 979-774-6633.

1. HEALTH INSURANCE

We accept many different insurance plans, and know most of the plans that we are covered under; however, with literally hundreds of different plans in our area, it is nearly impossible for us to keep up with them. We encourage you to call you insurance company and verify that we are providers under your plan.
It is the patient's responsibility to provide insurance information (current insurance cards, etc.) to us. If you have any new information or changes in your plan, it is your responsibility to let us know. We have a window of opportunity to bill your insurance company for services rendered. If we have the wrong information, then your insurance company will not pay and it will be your responsibility.
Please understand that though a patient may have insurance coverage, or a card, **it is ultimately the patient's responsibility to pay the bill in total** as some insurance plans have high co-pays and deductibles that are to be paid by the patient. Also, sometimes effective dates of coverage are confusing and you may not be covered when you think you are. Please verify your coverage before being seen.

2. CO-PAYS

Co-pays are the amount an insurance company demands that the patient pays at the time of service. Co-pays are to be paid upfront before a patient can be seen as requested by insurance plans. **If you do not have your co-pay at the time of service, you cannot be seen**. We accept credit cards, personal checks and cash. Please understand that a co-pay may only be part of your responsibility and your share may be more after the visit is filed with your insurance company. For instance, if you have a plan with a high deductible, you will be responsible for the total cost of your medical bills up until that amount is paid. If you have a lab-only visit, we routinely do not collect co-pays since most insurance companies do not require them. However, some insurance companies do require co-pays for lab-only visits. If your insurance company does, then it will be billed to you.

3. DEDUCTIBLES

Deductibles are the amount of money that must be paid by the patient before the insurance company begins to pay. This is the patient's responsibility. Often, we will not know if you have a deductible or how much it is until we receive the EOB (explanation of benefits) from your insurance company that informs us of your deductible and responsibility of payment. Your payment is expected in full at the time the EOB is received. A copy of the EOB is usually sent from your insurance company to you with "patient responsibility" or "due from patient" marked on it that shows how much your insurance company will pay and how much you owe.

4. ADJUSTMENTS

Different insurance companies and local physician billing alliances (BVPO, Alliance, etc.) have contracted with me and set the exact amount they pay for a given level of service for a visit or for a given procedure or lab. This amount differs between insurance companies, and as a result we will not know the exact amount until the EOB is sent to us from your insurance company after we bill them. For example, Insurance A may have agreed to pay us $10 for a certain lab. If we normally charge $12 for the lab, a $2 adjustment will be made, and the total charge will be $10. If you have not met your deductible or if your insurance company deems it your responsibility to pay us, then you will owe us $10, and not the full $12. When you have one of these plans, this is why we often cannot quote you exactly how much your total bill will be at the time of service.

5. LAB BILLING

For most insurance plans, except for Medicaid, Medicare and HMOs (Firstcare, Cigna) we bill the insurance company directly for lab services. The lab then charges us for the labs that they perform on our patients.

6. WELL CHILD CHECKS AND IMMUNIZATIONS

Immunizations often cost us nearly $100 per shot to purchase for patients. We rarely get reimbursed from insurance companies enough to break even on giving shots, but we want to offer this valuable service to our patients and the convenience of doing them here. **We ask that if you know that your insurance company does not pay for immunizations or if you have a large deductible that you know you will have a hard time paying, please inform us. You may qualify for an assistance program such as Texas Vaccinations for Children.** Otherwise, we could lose hundreds of dollars on one round of vaccinations, when programs could help with the expenses.

7. OUTSTANDING BALANCES

We understand that it may be difficult to pay your entire medical bill at once. Payment arrangements can be made with us and with Marway, our billing company. ***Before you may be seen again for a visit, at least one third of your outstanding bill must be paid at the time of visit.** We understand that healthcare can be very expensive, as it is very expensive to run a healthcare practice. We will try to do everything to minimize costs of tests, procedures, medicines, etc. without compromising patient's healthcare needs. If you are having difficult times financially and realize that there is no way that you will be able to pay any of your medical bills, please let me know at the time of the visit and we will try to do everything we can for you. **If an outstanding balance exists for an extended period of time, the balance will be forwarded to a collections agency, and you will be dismissed as a patient.**

8. MISSED APPOINTMENTS

We request that you give us a 24 hour notification if you are going to cancel or reschedule and appointment. We understand that mistakes are made and appointments are sometimes accidentally missed. While some offices charge a $100 missed appointment fee, we are more lenient and understand that it sometime happens. Please respect our practice and more importantly, remember that other patients may not have been able to be seen that day (sick children, etc.) due to the fact they could not be scheduled because of a full schedule. It is not fair for anyone if you make an appointment and do not keep it. **If this becomes a recurring problem and two or more appointments are missed or cancelled without at least 24 hours notice, we will have to dismiss you as a patient.**

9. LATE FOR APPOINTMENT/WALK-INS

Although walk-in appointments can often be "worked-in," please understand that on full scheduled days, we may not be able to see you. We rarely have to turn patients away, but realize that it is not fair for other patients with prior scheduled appoints to have to wait because they were "bumped" by a walk-in visit. Likewise, if you are late for your appointment it causes everyone behind you to be late. So, to be fair and courteous to patients who have scheduled appointments, we will try to see them on time by first priority and will then attempt to work in walk-ins or people late for their appointments.

10. MEDICAID

Medicaid patients will be treated the same as any other insurance, except for the fact that Medicaid rules mandate that the patient show their up to date card each visit. **If you do not have your card for that month, you will need to get it before you can be seen, and will most likely need to be rescheduled. Forgetting to bring your card will be treated as a missed appointment, as effectively it is**. Like missed appointments, if it becomes a recurrent problem, you will be dismissed as a patient.

11. SELF-PAY (NO INSURANCE) PATIENTS

We welcome self-pay patients and understand your difficult situation. We will try to do everything we can in order to keep your healthcare expenses at minimum. We will charge based on level of service at the current level that Medicare reimburses us for that service, rounded up to the nearest $5 dollars (exact amounts are available at your request). So, we will not be able to determine the exact cost of the visit until the visit is complete, at which time the payment is due in full. The costs of labs and other procedures will be discussed with you during the visit and we will give a 50% discount of our regular charge on those if paid the on the day of service. Otherwise, labs and procedures will be billed for the full price. **At the time of service, we will hand you a self-pay fee schedule.**

12. NARCOTICS AND POTENTIALLY ABUSED OR ADDICTING MEDICATIONS

Narcotics, such as opiate pain medications, and potentially addictive medications such as tranquilizers, Xanax, Soma, Adderal, etc. are treated very carefully. I will not write these medications lightly or often as they can be very dangerous and addictive. If you are here just to get these medications and not to actually treat a medical condition, leave now as you will not be satisfied. I treat pain aggressively and compassionately, but will do everything to prevent potentially harming patients more by making them addicts. If you are receiving these types of medications from other sources, medical or otherwise, and do not inform me of this, or exhibit drug-seeking behavior (trying to fill prescriptions too early, altering prescriptions, taking another person's medications or giving out your medications, etc) you will be dismissed as a patient and will be reported to appropriate authorities. If you realize that you may have a problem with these types of medications, please talk to me about it and we will do everything we can to get you help.

13. PHONE CALLS / REFILLS / AFTER-HOURS CALLS

We will do everything possible to return your calls in a timely manner. Most of the time we can call you back fairly quickly, maybe even the same day. However, please understand that the patients with appointments come first. Please call you pharmacy for refills and most of the time, they will contact us with the request. This is the most efficient and quickest way to get the prescription refilled. Please do not wait until the last day to get your medicines refilled.

Either Dr. Bacak, or another doctor from his call group is on call at all times. We ask that you respect the on-call doctor at night and **only call if you believe something is an emergency or that has to be taken care of before the next morning.** Understand that the on-call doctor will not call in any narcotics, antibiotics, or addictive medicines or simple refills that could wait until the next morning. If your matter is urgent please call 911 or visit an urgent care facility for urgent care.