**Dr. Fredric C. Puckett, PLLC Patient Registration** (Please Print Clearly)

Patient's last name:_____ First:_____Middle:_____

Date of birth:_____ Male or Female Marital status: S M W D

Street address: _____

City: _____ State:_____Zip code: _____

Preferred contact number:_____Alternate number: _____

Social Security number:_____Driver's License number: _____

Occupation:_____Employer: _____

Employer's address: _____

Employer's phone number: _____

Emergency contact name:_____Relationship to patient: _____

Primary contact number:_____Alternate number: _____

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1. Full name of person responsible for payment: _____

2. Full address (if different from patient): _____

3. Primary contact number: _____ Alternate number: _____

Is patient insured? Yes or No (If yes, please give your insurance card(s) to the receptionist).

Is insured the same as person responsible for payment? Yes or No. If no, please complete the following:

Insured's name:_____Date of birth: _____

Insured's address: _____

Contact number: _____

Patient's relationship to insured: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I authorize Dr. Fredric Puckett, PLLC to release any information required to process my claims.

**Patient or Guardian Signature:_____Date:** _____

## Health History

1. Name of previous primary care physician (seen within the last five years):_____

2. Pharmacy name and location (Ennis, Waxahachie, etc.) or preferred local mail order pharmacy:_____

3. List all medications that you take. Include over the counter medication, vitamins, and supplements. If more space needed, please use the back of this page.

| Medication name | Dosage | Times per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

4. Have you ever experienced an adverse reaction to a medication? Yes or No

If yes, please describe:

| |
|---|
| |

5. Are you allergic to latex? Yes or No

6. Please list any other physician(s) that you see on a regular basis or have seen in the past year:

| Physician's name | Specialty |
|---|---|
| | |
| | |
| | |
| | |

7. Alcohol use (circle one)

| | | | |
|---|---|---|---|
| Never | Rarely | Regular | Daily |

Please describe frequency and type(s) of alcohol consumed:

| |
|---|
| |

8. Tobacco use (circle one)

| | | | | |
|---|---|---|---|---|
| None | Cigarette | Cigar | Pipe | Chew |

| | | |
|---|---|---|
| Age started | Age stopped | Average use per day: |

9. Please circle those conditions with which you have been diagnosed. Write year of diagnosis.

| | | | | |
|---|---|---|---|---|
| ADD or ADHD | AIDS or HIV | Anemia | Anxiety | Arthritis |
| Asthma | Back Trouble | Bladder Infections | Bleeding Tendency | Blood or Plasma Transfusions |
| Bronchitis | Cancer<br>Type: | COPD | Depression | Diabetes<br>Type: |
| Epilepsy | Glaucoma | Heart Disease | Hemorrhoids | Hepatitis |
| Hernia | High Blood Pressure | High Cholesterol | Hives or Eczema | Infectious Mono |
| Insomnia | Kidney Disease | Low Blood Pressure | Lung Disease | Measles |
| Migraine Headaches | Mitral Valve Prolapse | Neuropathy | Reflux or GERD | STDS |
| Seizures | Shingles | Sleep Apnea | Stroke | Thyroid Disease |
| Tuberculosis | Ulcer | Venereal Disease | | |

| |
|---|
| Other: |

10. Please circle the diagnostic procedures you have had. Write the year of procedure.

| | | | |
|---|---|---|---|
| Colonoscopy | Diabetes Screening | Aortic Aneurysm | Cartoid Ultrasound |

| |
|---|
| Other: |

11. In what year did you last receive the following vaccines?

| | | | | |
|---|---|---|---|---|
| Tetanus | Pneumonia | Pertusis | Shingles | Flu |

12. Please circle any major surgeries that you have had and write the year of operation next to it.

| | | | |
|---|---|---|---|
| Appendectomy | Breast | Bypass | Cataract |
| C-Section | Ear Tubes | Esophagus | Gallbladder |
| Heart Angioplasty | Hernia | Hysterectomy | Kidney |
| Lasik | Organ Transplant | Pacemaker | Prostatectomy |
| Rhinoplasty | Septoplasty | Sinus | Tubal Ligation |
| Weight Loss | Other: | | |

13. Have you had problems with anesthesia? Yes or No If yes, please describe:

| |
|---|
| |

14. Have you ever had a serious injury or major accident? Yes or No If yes, please describe:

| Type of accident | Date | Treating hospital or physician's name and location |
|---|---|---|
| | | |
| | | |
| | | |

15. Circle any conditions that a BLOOD RELATIVE has had. Describe their relationship to you (brother, sister, uncle, etc.) and if they are from your maternal or paternal side (mom's brother). If necessary, please continue on the back of page:

| | |
|---|---|
| Allergic Rhinitis (Hay Fever) | Alzheimer's Disease |
| Anemia | Anesthesia Problem |
| Arthritis | Asthma |
| Birth Defects | Bleeding Problem |
| Cancer (type) | Coronary Artery Disease |
| Depression | Diabetes, Type 1 |
| Diabetes, Type 2 | Epilepsy (Seizures) |
| Eye Conditions | Glaucoma |
| Heart Attack | Heart Disease |
| Hearing Problems | High Cholesterol (Hyperlipidemia) |
| High Blood Pressure (Hypertension) | Kidney Diseases |
| Lupus | Migraine Headaches |
| Osteoarthritis | Osteoporosis |
| Rheumatoid Arthritis | Stroke |
| Thyroid Disorders | Tuberculosis |
| Ulcer | Other: |

16. Please use this space to tell us anything else that you would like for the provider to know about you or your health history.

**Authorization for Disclosure of Health Information**

Please take a moment to carefully complete this form. Health information released by other doctors, clinics, hospitals, etc. may inform this provider's treatment plan for you

1. Patient's full name: _____
2. Date of birth: _____
3. I authorize the disclosure of this patient's health information for continuity of care. Yes or No
4. The following individual or organization is authorized to make the disclosure:

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone number: _____ Fax number: _____

5. The type and amount of information to be used or disclosed is as follows:

| | | |
|---|---|---|
| Entire Health Record | ER Records | Pathology Report |
| Operative Procedures | History and Physical | Hospital Records |

| |
|---|
| Other (please specify): |

6. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
7. This information may be disclosed to the following for continuation of care:

    Dr. Fredric C. Puckett, PLLC
    2203 W. Lampasas St., Suite 111 Ennis, Texas 75119
    Phone: 972-875-6200 Fax: 972-875-6414

8. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to anyone to whom I have give authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Fredric Puckett or Pamela Rodriguez.

**Signature of patient or legal representative:** _____ **Date:** _____

**Signature of witness:** _____ **Date:** _____

## Patient's Confidentiality Instructions

Representatives of this office cannot share any personal health information to anyone other than the patient, or for minors, the patient's legal guardian without explicit permission from the patient or their legal guardian*

Patient Name:_____DOB:_____

**PLEASE CHECK YOUR PREFERENCE BELOW**

___Representatives of Dr. Fredric Puckett, PLLC may discuss my medical information **ONLY** with me.

___I give my permission for representatives of Dr. Fredric Puckett, PLLC to share my medical information with the following personal contacts:

Name _____ Relationship to you: _____

Name _____ Relationship to you: _____

Name _____ Relationship to you: _____

You may leave medical information (ex: test results or answers to medical questions) on my voicemail. **Yes or No** (please circle)

Patient's Preferred Phone Number: _____

Patient Signature:_____Date: _____

*Release of information necessary for the provision of medical care and billing purposes are automatically authorized under HIPAA regulations.

## Billing Policy and Procedures

This a professional office that renders quality care to patients. Our duty is to preserve the dignity and confidentiality of our patients while receiving appropriate payment for the care provided.

This practice is obligated to provide medically necessary services to patients as required by the standard of care set by the profession and contracts with insurance carriers. This practice keeps its agreements and will not bill or charge patients when our contracts do not permit it. Holders to certain insurance policies may be required to pay for services at time of your appointment and submit your claim for reimbursement from the insurance company.

1. **Payment is required at the time of service. This may be a co-payment, co-pay, deductible, or full payment, absent an insurance carrier contract provision to the contrary.**
2. We accept most insurance plans. **It is your job, as the patient, to make sure Dr. Puckett is an in-network provider for your specific plan before you arrive for your appointment. Failure to do so, may result in your having to reschedule the appointment.**
3. For your convenience, we will submit claims for payment directly to the insurer, with a few exceptions**. Please remember, your insurance agreement is between you and your insurer. You are ultimately responsible for any charges generated in this office.** In order to submit claims to any insurer, we must have the following on file: a copy of the patient's current insurance card; the policy holder's name, contact information, and their relationship to the patient; the patient's correct contact information; and other information as necessary. **If your policy is one of the exceptions or if we do not have enough information to process a claim, you will be responsible for full payment at the time of service.**
4. You are responsible for any outstanding balance, such as non-covered charges as outlined in your health insurance company policy. These changes are listed on the Advance Beneficiary Notice.
5. If you have not settled your account within a reasonable amount of time following the date of service, you will be contacted by our office with a request for payment.
6. If you maintain a balance that is more than 120 days past due and have not made any payments or contacted the practice about a financial hardship, your account will be classified as "delinquent account." **Patients who have delinquent accounts are required to provide full payment for services before being seen by the provider.**
7. If you maintain a delinquent balance for more than 150 days without making any payments or contacting the practice about assistance because of financial hardship, you may be dismissed from the practice.

I acknowledge that I have read and understood the **billing policy** and procedures for Dr. Fredric Puckett, PLLC.

**Patient or Guardian signature:** _____ **Date:** _____

## Patient Portal

**Lab results are not given over the telephone.** Results can be accessed via the Patient Portal. If you do not have an e-mail address or do not wish to access the Patient Portal you may request to pick-up a paper copy of your lab results at the office**. Questions concerning results can only be discussed during a scheduled office visit.** If you have questions about your results, please call the office to schedule an appointment with your provider.

Do you authorize Dr. Fredric Puckett, PLLC to create a **Portal** account for you? Yes or No

**If yes, please include e-mail address (write legibly):** _____

**Patient name:** _____

**Patient or Guardian signature:** _____

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## Appointments

1. A staff associate from our office will call 24 to 48 hours before a scheduled appointment to confirm that you will be here. **If you need to cancel an appointment, please call as soon as possible so that a patient on the waiting list can be scheduled in your place.** If you do not do this, you may be assessed a $50 penalty fee. Patients who fail do this more than two times per year, may be dismissed from the practice.
2. When possible, we will attempt to accommodate late arrivals. **However, if you arrive more than ten minutes late for your scheduled appointment you may be asked to reschedule.**
3. Please help us stay on schedule by discussing only the patient and subject(s) for which the appointment is scheduled. **Any questions regarding medications (including changes, concerns or upcoming refills) should be asked during the appointment. Questions posed outside of your appointment time may take 24 to 48 hours to answer (excluding weekends and holidays).**
4. When scheduling an appointment, **please disclose the name of any hospitals or doctors that have treated the condition to be discussed so that medical records or lab results may be obtained in time. Failure to do so, may result in needing to reschedule your appointment.**
5. Unfortunately, there will be times when the provider is running behind or has been called to the hospital for an emergency. When this occurs, patients already in the office may have the option to wait or be asked to reschedule. Patients who have not yet arrived will be notified of the delay and given the choice of either rescheduling or arriving at the office at a time when the provider can see them.

I acknowledge that I have read and understood the procedures for **scheduling and keeping appointments** with Dr. Fredric Puckett, PLLC.

**Patient or Guardian signature:** _____ **Date:** _____

## Prescription Refill Policy

1. Patients taking prescription medications must keep regularly scheduled appointments with the provider. The interval of these appointments depends on the condition being treated and the type of medication prescribed.
2. Please bring all your prescription bottles (or an updated medication list) with you to your appointments so that we can ensure the following:

- you are taking the correct medications and the correct doses
- we have an up-to-date list of your medications.

3.When a refill is needed, **please call your pharmacy first**. Otherwise, allow 24 to 48 hours for our office to send in refills of your medications and prepare any paper scripts.
4. If you call to request a refill and are overdue for a follow up visit and/or blood work (necessary for monitoring the safety or effectiveness of a medication), the provider may agree to call in enough medication to your pharmacy to last until we are able to schedule an office visit. **It is your responsibility to schedule an appointment before you run out of medication.**

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## Prior Authorizations of Medications

Some medications that your provider prescribes may need prior authorization through your insurance company. It can take up to two weeks to receive prior authorization from your insurance company. Not all medications will be approved because your physician feels it should be prescribed. We may need to change your medication to something that is covered under your plan. Please familiarize yourself with your individual insurance guidelines. You can obtain a copy by calling your customer service number on your insurance card.

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## Referrals

Your health insurance carrier may have established the guidelines for referrals and prior authorizations. Please familiarize yourself with your insurance company's guidelines. Certain testing ordered by the provider may require prior authorization from your insurance company. Clinic support staff assist the provider in submitting authorizations to your insurance company. Please keep in mind that this can be a very time-consuming process and that your insurance company may not authorize the request. Your provider may appeal, the decision, or order a different test.

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