Dr. Fredric Puckett, Family Medicine Clinic, New Patient Registration (Print Clearly)

Patient Information

Last Name_____ First_____ Middle_____

Date of Birth_____ Gender M or F Driver License # and Issuing State (if applicable) _____

Language_____ Race_____ Ethnicity_____

Mailing address_____

City_____ State_____ ZIP code_____

Preferred Phone Number: _____

Consent to call Yes or No (circle one) Consent to text Yes or No (circle one)

Parent Information

Mother's Name_____ Date of Birth_____

Driver's License Number and Issuing State _____

Cell Phone _____ Work Phone _____

Employer Name and Address: _____

Father's Name_____ Date of Birth_____

Driver's License Number and Issuing State _____

Cell Phone _____ Work Phone _____

Employer Name and Address _____

Emergency Contact Information

Full Name_____ Relationship to Patient _____

Preferred Phone Number_____

Insurance Information

Name of Insurance Company _____ Phone_____

Claims Mailing Address_____

Name of Primary Insured_____ Policy #_____

Group # _____ Patient ID_____ Effective Date_____

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

Patient or Guardian Signature _____ **Date**_____

Health History

Birth History

Complications During Pregnancy? Yes or No

If yes, please specify_____

Delivery Type (circle one) Vaginal or Caesarian

If Caesarian, why? _____

Gestational Age _____ Birth Weight _____ Birth Length_____

Hearing Screen (circle one) Passed Failed Not Done

Treatment History

Hospitalizations (Facility Name, Dates and Reason) _____

_____

Surgeries (Dates and Reason) _____

_____

Specialists Seen (Name, Type and Reason) _____

_____

Medications

Pharmacy name and location _____

List all medications that the patient takes. Include over the counter medication, vitamins, and supplements. If more space is needed, please continue on the back of page.

Medication name	Dosage	Times per day

Has the patient ever experienced an adverse reaction to medication? Yes or No

If yes, please describe: _____

Is the patient allergic to latex? Yes or No

Health History Continued

Chronic Medical Problems (circle all that apply)

ADD or ADHD	Allergies (Food)	Allergies (Seasonal)
Allergies (Medication)	Anemia	Asthma
Constipation	Developmental Delay (Specify)	Diabetes
Eczema	Headaches	Heart Disease
Problems with Menstrual Cycle	Seizures	Other

Family History (check all that apply and list family members with medical condition)

Diabetes	Seizures	Asthma
Allergies (Food, Medication, or Seasonal)	High Cholesterol	Anemia
Heart Disease	High Blood Pressure	Cancer (Type)
Eczema	Bleeding Disorder	Liver Disease
Kidney Disease	Crohn's Disease or IBS	Mental Illness

Other (please specify) _____

Medical Records Request Form

Patient Name _____ Date of Birth _____

Please send the following (circle all that apply)

Entire Medical Record	History and Physicals
Problem-Focused Notes	Vaccination Records
Lab Records	Radiology Results
Newborn Nursery Record	Other:

Please release my protected health information FROM the following person/entity:

Name _____

Street _____

City _____ State _____ Zip_____

Phone_____ Fax_____

By signing this form, I authorize you to release confidential health information about my child by releasing a copy of the medical records to the entity below:

Please release my protected health information TO:

Dr. Fredric Puckett, Family Medicine Clinic
L. Elaine Donet, APRN, FNP-BC, Heather Hall, APRN, FNP-C, Lance Hall, APRN, FNP-C, and Jamie Rowland, APRN, CPNP
2203 W. Lampasas St. Suite 111
Ennis, TX 75119
Phone: 972-875-6200 Fax: 972-875-6414

Parent/Legal Guardian Signature _____ Date_____

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information 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 bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information 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, your protected health information 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 protected health information 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 protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information 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 protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information 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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be **made only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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 are statements of your rights with respect to your protected health information. **You have the right to inspect and copy your protected health information (fees may apply)** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information 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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to your protected health information – 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 – **You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures:** pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice, and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Nora Puckett	972-875-6200	office@ffmclinic.com
HIPAA COMPLIANCE OFFICER	Phone	email

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 protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

I, _____, have received a copy of the Notice of Privacy Practices of Dr. Fredric Puckett, PLLC.

_____

Name of Patient or Legal Guardian and Date

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.

- Complaints related to billed charges shall be directed to the Billing Manager for resolution.
- **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.**
- 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 the your appointment. Failure to do so may result in your having to reschedule your appointment.**
- 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.**
- 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.
- 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.
- 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.**
- 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, what is your email? _____

Patient name _____

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.
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.**

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.

Referrals

Your health insurance carrier may have established the guidelines for referrals and prior authorizations. Please familiarize yourself with your insurance companies 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.

Late, Cancellation and No-Show Policy

Five Minute Late Policy

When a patient is more than 5 minutes late for an appointment, that appointment will be rescheduled. We will do all we can to find an appointment on the same day (possibly with a different provider), but we cannot guarantee it will be same day. Please be aware that we have limited times for check-ups and rescheduled check-up appointments could be several weeks delayed. We value all of our families and recognize the difficulties you face in trying to coordinate all the demands made upon your time. This late policy, however, is what we need to run our clinic in a timely manner. Please be aware that when a patient is late all of the visits following are affected and delayed. I have read and understand the above 5-minute late policy (sign below)

Patient name _____

Patient or Guardian signature_____**Date** _____

Cancellation and No-Show Policy

When an appointment is missed without a call to cancel or reschedule, it is considered a **NO SHOW.** When a patient does not show up for their appointment this keeps us from seeing other patients that could have been seen instead. Patients who no show will be charged a $**50 no show fee**, which is the sole responsibility of the patient and must be paid in full before the patient's next appointment. Patients who no show will receive a letter advising them of the missed appointment. Patients who no show three (3) or more times in a 12 month period, may be dismissed from the practice, thus they will be denied any future appointments. We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel or reschedule your appointment you do so at least 1 hour in advance. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. Patients who do not call at least **1 hour** in advance to cancel or reschedule an appointment will be charged a $25 late cancellation fee. Again, we value you as a patient! These policies help us ensure that our appointment schedules are fully utilized for all of our patients.

I have read and understand the above cancellation and no show policy (sign below).

Patient or Guardian signature_____**Date** _____