

Welcome to Lake Worth Minor Emergency Center

We are dedicated to serving the community by providing top quality, extended-hour medical care. In order to have the resources to meet this need, we must insist that payment is due at the time of service, therefore we do not bill for services. As an independent medical provider, we do not accept any type of insurance. We do not accept Medicaid. We do not accept Medicare as payment. Medicare patients see bottom of this page.

Please choose the method of payment you will be using today.

Cash ☐ Check ☐ Master Card ☐ Visa ☐ American Express ☐ Discover ☐

Office Visits: Regular hours are provided Monday through Friday, excluding holidays, until 4:00 p.m., weekends, and holidays for your convenience.

Regular Hour Rate:

New Patient	\$110.00
Established Patient	\$90.00
Follow-up Visit	\$60.00

Extended Hour Rate:

(Signed In After 3:30 P.M. & Weekend & Holidays)

Established Patients	\$110.00
Follow-up Visit	\$70.00
New Patients	\$120.00

Please note that the patient must have signed in prior to 3:30 p.m. in order to qualify for the Regular Office Hour Rate.

Patient Information

Name: _____ Male ☐ Female ☐
First Middle Last

Marital Status:(choose one) Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐

D.O.B.: _____ Age: _____ SSN#: _____ DL#: _____

Address: _____ City: _____ ST: _____ Zip: _____ Home Phone: _____

Employer: _____ Address: _____ Work Phone: _____

Guardian / Spouse Information Cell Number: _____

Name: _____ Male ☐ Female ☐
First Middle Last

D.O.B.: _____ Age: _____ SSN#: _____ DL#: _____

Employer: _____ Address: _____ Work Phone: _____

Whom shall we contact in case of emergency? _____ Phone: _____

Do you have Medicare? _____ If yes, is this your primary insurance? _____ If yes, we will file with Medicare for you. If any reimbursement is due, you will be paid directly by Medicare.

Signature: _____
(Patient OR Parent/Guardian of Minor Patient)

Date: _____

PRIVATE PAY AGREEMENT

I UNDERSTAND THAT THE LAKE WORTH
MINOR EMERGENCY IS ACCEPTING ME AS
A PRIVATE PAY PATIENT. I WILL BE
RESPONSIBLE FOR ANY SERVICES
I RECEIVE. THE PROVIDER WILL NOT FILE
A CLAIM WITH MEDICAID OR ANY PRIVATE
INSURANCE FOR SERVICE PROVIDED TO ME.

PAYMENT IS DUE AT THE TIME OF SERVICE

Signed: _____

Date: _____

LAKE WORTH MINOR EMERGENCY
6302 LAKE WORTH BLVD SUITE A
Lake Worth, TX 76135
(817) 237-8273 Fax (817)237-0374
Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

LAKE WORTH MINOR EMERGENCY at 817-237-8273.

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

- 1. Treatment.** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
- 2. Payment.** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health care operations.** Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
- 4. Our practice** may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
- 5. Release of information to family/friends.** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- 6. Disclosures required by law.** Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

- 1. Public health risks.** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
 - Maintaining vital records, such as births and deaths,
 - Reporting child abuse or neglect,
 - Preventing or controlling disease, injury or disability,
 - Notifying a person regarding potential exposure to a communicable disease,
 - Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
 - Reporting reactions to drugs or problems with products or devices,
 - Notifying individuals if a product or device they may be using has been recalled,
 - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
 - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health oversight activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and similar proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- 4. Law enforcement.** We may release PHI if asked to do so by a law enforcement official:
 - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
 - Concerning a death we believe has resulted from criminal conduct,
 - Regarding criminal conduct at our offices,
 - In response to a warrant, summons, court order, subpoena or similar legal process,

- To identify/locate a suspect, material witness, fugitive or missing person,
 - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
- 5. Deceased patients.** Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- 6. Serious threats to health or safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- 7. Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 8. National security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
- 9. Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- 10. Workers' compensation.** Our practice may release your PHI for workers' compensation and similar programs.
- E. Your rights regarding your PHI:**
- You have the following rights regarding the PHI that we maintain about you:
- 1. Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to LAKE WORTH MINOR EMERGENCY specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
- 2. Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to LAKE WORTH MINOR EMERGENCY. Your request must describe in a clear and concise fashion:
- The information you wish restricted,
 - Whether you are requesting to limit our practice's use, disclosure or both,
 - To whom you want the limits to apply.
- 3. Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to LAKE WORTH MINOR EMERGENCY, in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- 4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to LAKE WORTH MINOR EMERGENCY. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
- 5. Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented - for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to [insert name or title, and telephone number of a person or office to contact for further information]. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- 6. Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact LAKE WORTH MINOR EMERGENCY at 817-237-8273.
- 7. Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact LAKE WORTH MINOR EMERGENCY at 817-237-8273. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- 8. Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact LAKE WORTH MINOR EMERGENCY 817-237-8273.



6302-A Jacksboro Hwy.
Fort Worth, TX 76135
(817) 237-8273

Notice of Privacy Practices Acknowledgement

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.

Signature of Patient or Guardian

Date

Printed Name

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Privacy Notice, but was unable to do so as document below.

Date: _____ Initials: _____ Reason: _____

Release of Patient Information Consent Form

I hereby authorize Lake Worth Minor Emergency to release any of my medical information to the following person/persons:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

☐ None

Patient/Guardian Signature: _____

Print Name: _____ Date: _____

Witness Signature: _____ Date: _____

Consent to Communicate via Email & Text Message

Patient Consent for Email and Text Message Communication

Lake Worth Minor Emergency wishes to expand its method of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and LWMEC would like to communicate with you regarding confirming appointments, referral appointments, and return for lab result appointments, which means we need your consent.

Email and text communication will never be used for urgent communication.

Should I wish to withdraw consent I accept that I must give at least 5 working days' notice in writing quoting the email and phone number listed below. I will advise the practice if I change my phone number and understand that a new consent form is required.

I _____ give Lake Worth Minor Emergency Clinic consent to contact me via:

- ☐ Email and Text Email: _____
- ☐ Email Only
- ☐ Text Only Cell Phone #: _____
- ☐ Neither

Patient Name: _____

DOB: _____

Signature: _____

Date: _____

Parent or Guardian signing for a child of 17 years old and under, please state your relationship:

Consent must be signed by actual patient unless a child

MEDICAL HISTORY

Name _____ Age _____ DOB _____ Today's Date _____

Past Medical History

Check (✓) all that apply:

_____ Allergies	_____ Cholesterol	_____ Gout	_____ Peripheral Artery Disease
_____ Anemia	_____ Chronic Liver Disease	_____ Hearing Impairment	_____ Prostate
_____ Arthritis	_____ COPD	_____ Heart Disease	_____ Psoriasis
_____ Asthma	_____ Diabetes	_____ Heart Failure	_____ Senile Dementia
_____ Blindness	_____ Diabetic Peripheral Neuropathy	_____ High Blood Pressure	_____ Stroke
_____ Cancer	_____ Diverticulosis	_____ Incontinence	_____ TB
_____ Chemo/Radiation	_____ Dizziness	_____ Kidney Stones	_____ Thyroid
_____ Carotid Stenosis	_____ Eczema	_____ Macular Degeneration	_____ Ulcers
_____ Cataracts	_____ Glaucoma	_____ Osteoporosis	_____ Venous Insufficiency/Stasis

Medical Problems: _____

Medications: _____

Allergies: _____

Allergies to Anesthesia? Yes No

Past Surgical History: _____

Past Hospitalizations: _____

Social History:

Marital Status: M D S W

Monogamous? Y N Homosexual? Y N

No. Children _____ Residence _____

Live Alone? Y N Retired? Y N

Occupation: _____

Industrial Exposures: _____

Smoker? Y N Packs/day _____

Ex Smoker? Y N Date Quit _____

Alcohol? Y N Drinks/day _____

Mammogram _____

Drugs? Y N _____

Calcium Supp? Y N _____

Dietary HX _____

Exercise _____

Seatbelts used? Y N

Family History: Mom _____ Dad _____ Sibs _____

Y N Coronary Artery Disease _____

Y N Hypertension _____

Y N Diabetes _____

Y N Thyroid Disorder _____

Y N Breast Cancer _____ Colon Cancer _____

Y N Other _____

Review of Systems ✓= WNL

HEENT _____

Pulmonary _____

Cardiac _____

GI _____

GU _____

GYN _____

MS _____

Last PAP _____ Last _____

Colonoscopy _____

Dental Exam UTD _____ Eye Exam UTD _____

Screening Recommended _____

Driver? Y N _____

Flu Vaccine _____ Last DT _____ Pneumovax _____

Assistive Devices: Wheelchair _____

Walker _____

Cane _____

Crutches _____

Eyeglasses _____

Hearing Aid _____

Dentures _____

Dr. Jerry Davis, D.O. _____ Dr. Tamara Hanby, D.O. _____ Dr. Scott Hughes, D.O. _____