Patient Information **Patient Registration Form (eCW)** **(Please Print)**

Patient's Name (Last) _____ (First) _____ (MI)_____
Address _____ City _____State _____Zip _____
Date of Birth _____ Sex: Female ____Male ____Transgender ____
Married____ Single____ Divorce____ Widow____
Race (please check one)
Hispanic __ African American/Black __ Asian __ American Indian__
White/Caucasian __ Native Hawaiian __ Other _____
Home Phone _____Cell _____ Work _____ Ext _____
Employer Name _____
Email Address _____ Last 4 of social: _____
Pharmacy Name, Address, Phone _____

Emergency Contact: _____
Last _____ First _____
Phone Number _____ Relationship to Patient _____
Address _____City _____ State _____ Zip _____
Home _____Cell _____Work _____

Primary Insurance Information _____
Insurance Company Name: _____Phone: _____
Name of Insured: _____Patient Relationship to Insured: _____
Subscriber ID _____ Group ID _____ Co/Pay_____
Effective Date: _____Termination Date _____ Date of Birth MM__/DD__/YY__

Secondary Insured Information _____
Insurance Company Name: _____Phone: _____
Responsible Party: Another Patient ____ Guarantor ____ Self ____
Responsible Party Name: Last _____First: _____ (MI) ____
Date of Birth: MM _____/DD_____ /YYYY_____
Email Address: _____Sex: Female ____ Male ____
Address: _____City: _____ State: _____ Zip: _____

PLEASE COMPLETE FORMS IN BLACK INK ONLY

McKinney Ranch Medical Care & Wellness

Janet Lin, M.D.

Health History Form

Name: _____ Date of Birth: _____ Today's Date: _____

What brings you to the clinic today? _____

Depression Screening

In the last 2 weeks, have you had less pleasure in doing activities that you normally do? Yes / No

Any feelings of being down, depressed or hopeless? Yes / No

MEDICATIONS

Name	Dose	Frequency	Start date

MEDICAL CONDITION

Conditions	Date Diagnosed	Type of Treatment Received	Name of Specialist

Name:_____ DOB:_____

ALLERGIES

Drug/Foods	Reaction

SURGERIES

Type of Surgery	Date

FAMILY HISTORY

Please check if unknown family history ___

Relative	Deceased	Medical problems	Age at Death/ Cause
Father	Y / N		
Mother	Y / N		
Brother	Y / N		
Sister	Y / N		
Paternal Grandfather	Y / N		
Paternal Grandmother	Y / N		
Maternal Grandfather	Y / N		
Maternal Grandmother	Y / N		
Paternal Uncles/Aunts			
Maternal Uncles/Aunts			

SOCIAL HISTORY

Marital status:	How many children:
Occupation:	Education level:
Do you currently smoke? Y / N Former smoker? Y / N	Age started: _____ How many packs per day: _____ Age quit:
Do you drink alcohol? Y / N	How often? daily / weekly / monthly / rarely How many drinks? How often 6 or more drinks in 1day? weekly / monthly
Do you exercise regularly? Y / N	Times per week? Minutes per week? Types of exercise:

Name:_____ DOB:_____

HEALTH MAINTANCE

Date of last Mammogram		Date of last PAP smear				
Date of last PSA		Date of last bone density				
Date of last colonoscopy When due for next?		Date of last stool testing				
Date of last eye exam		Any diabetic eye changes?	Y / N			
Last EKG		Last stress test				
Last cholesterol		Results of cholesterol	Total	Triglyceride	HDL	LDL

IMMUNIZATIONS

Influenza:	Pneumovax:	Prevnar 13:	Tetanus (Td/ Tdap) :
Shingrix Date #1 Date #2	Zostavax:	HPV :	Hepatitis A : Hepatitis B :

SPECIALISTS

Name/Specialty	**Office Phone/Fax**

WOMENS HEALTH

Last menstrual period:	Current method of contraception:
Number of pregnancies:	Number of live birth? Number of miscarriages/abortions?

PREFERRED PHARMACY

Local: _____ **Phone:** _____ **Fax:** _____

Mail Order: _____ **Phone:** _____ **Fax:** _____

MCKINNEY RANCH MEDICAL CARE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient Initials) **Notice of Privacy Practice.** I acknowledge that I have received the practices notice of Privacy practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosers, I understand that I may contact the Privacy Office designated on the notice if I have question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of the Privacy Practices.

_____ (Patient Initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patients behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under work compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultation, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my heath records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. The consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne disease, such as HIV and AIDS.

Disclosure to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communication results, findings and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

I consent to email/phone calls for Appointment Reminders, Imaging (X-ray, CT, MRI etc.) Procedures (Mammograms, Colonoscopy, BMD, Physicals etc.)

Patients in our practice may be contacted via email/phone call to remind you of any Appointment Reminders, Imaging (X-ray, CT, MRI etc.) Procedures (Mammograms, Colonoscopy, BMD, Physicals etc.) or obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time, I provide an email address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communication/information at that email provided to the practice.

The email address that I authorize to receive email message for Appointment Reminders, Imaging (X-ray, CT, MRI etc.) Procedures (Mammograms, Colonoscopy, BMD, Physicals etc.) and general health reminders/feedback/ information is _____.

The practice does not charge for this service

Revocation

I hereby revoke my request for future communications via email.

___ I hereby revoke my request to receive any future appointment reminders, feedback and general health via emails

NOTE: This revocation only applies to communication from this Practice.

Patient Name: _____

Patient Signature: _____ Date: _____ Time: _____

Contact Authorization

I wish to be contacted at the following:

- Home: _____
- Cell: _____
- Work: _____

Patient Signature _____ Date: _____

The duration of this authorization is indefinite unless otherwise revoked in writing

McKinney Ranch Medical Care & Wellness

Patient General Consent to Treat

I, the undersigned, hereby consent to the following

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/ tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.
- Performance of minor in-office procedures that are medically necessary

I fully understand that this consent is given in advance of any specific diagnostic or treatment

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that McKinney Ranch Medical Care may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Signature (or responsible party) **Date**

McKinney Ranch Medical Care & Wellness

FINANCIAL POLICY

We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your care. The following is a statement of our FINANCIAL POLICY that we require that you read, agree to and sign prior to any treatment.

We accept cash, checks, credit cards and money orders as form of payment.
Extended payment plans are available with prior approval

MEDICARE/MEDICAID
As a participating provider for these programs, we accept assignment of benefits and will file all insurance claims for you. You are responsible for full payment of any deductible and/or co-insurance at the time service is rendered. All secondary/ supplemental policies will be filed with your carrier.

HMO / PPO AND OTHER MANAGED CARE
We will file all insurance claims for you. It is your responsibility to present your insurance card prior to service being rendered. If we are not participating provider for your managed care plan, you will be held responsible for full payment of your bill. Also, payment of applicable and co – payments is due at the time service is rendered.

OTHER INSURANCE
As a courtesy, we will file your insurance, however, you must provide all insurance information and a completed claim form (if required) at the time of service. Please understand that your policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, the balance is your responsibility whether your insurance company pays or not. Should you elect to file your own insurance claim, you will be responsible for all charges at the time of service. Our practice is committed to providing the best possible treatment and we charge what is usual and customary for our area. You are responsible for paying the bill in full as deemed appropriate, regardless of the insurance company's determination of usual and customary rates.

SELF PAY
Payment in full is due at the time of service. Payment plans may be arranged if necessary, although all account balance shall be paid in full within 6 months.

DELINQUENT ACCOUNTS
Accounts that are not paid in full satisfactory arrangements not made within 90 days of service rendered are considered delinquent. Delinquent accounts may be referred to a collection agency, nationwide credit bureau or to our attorney for further action.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

By signing below, I have read, understand and agree to the above Financial Policy

_____ _____

Patient Signature (or responsible party) *Date*

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

I hereby authorize _____ to release and
(Office Name and Phone Number)
disclose health information about me as described below to the following individuals or entities:

McKinney Ranch Medical Care & Wellness
3950 S. Ridge Rd Suite 100
McKinney TX 75070
Phone: 972-540-1688 Fax: 972-540-5888

Date of Service: _____

O Radiology Images	O Discharge Summary	O Complete Medical Records
O Radiology & Imaging Reports	O Pathology Report	O Oncology Reports
O Lab Reports	O ER Record	O Operative Reports
O Cardiology Reports	O Consultation Report	
O History and Physical Notes	O Wound Care Clinic Records	

Other: _____

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations.

REASON FOR DISCLOSURE
My health information is being released or disclosed for the following reasons:

O Personal O Insurance Eligibility/Benefits O Further Medical Care

O Legal Investigation or Action O Other (please specify) _____

AUTHORIZATION EXPIRATION – this authorization is valid (check one):

O From today forward for 180 days, only for information requested on this form

O For patients to indicate a shorter time frame only: From _____ Until _____

X: _____ DATE: _____
(Signature)