ConquestMD®
Spine Care and Sports Medicine, PLLC
6850 TPC Drive, Suite 116, McKinney, TX 75070 phone: (214) 544-9887 Fax: (214) 544-9888 www.conquestmd.com

Patient Demographics

Patient Information: (please print)

Patient's legal name: _____ Date of Birth: _____ Gender: M / F

Address: _____ City: _____ State: _____ Zip Code:_____

Home #: _____ Work #: _____ Cell #: _____

Driver's License #: _____ Social Security #: _____ E-mail: _____

Ethnicity: _____ Preferred Language: _____ Marital status: Single / Married / Divorced

Primary Care Physician: _____ PCP Phone #: _____
(First and Last Name, MD or DO)
PCP Fax #: _____

Pharmacy Address: _____ Pharmacy Phone #: _____

Pharmacy Fax #: _____

Patient/Parent Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Is this a work related injury? Yes / No

If patient is under 18 years of age or residing with parents, please complete this section.

Mother's name: _____ Date of Birth: _____ Phone #: _____ SS #: _____

Father's name: _____ Date of Birth: _____ Phone #: _____ SS #: _____

Insurance Information:

Primary Insurance Company: _____ Policyholder's Name: _____

Policyholder's Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Policyholder's Employer: _____

Policy ID#: _____ Group #: _____

Secondary Insurance Company: _____ Policyholder's Name: _____

Policyholder's Date of Birth: _____ Social Security #: _____

Relationship to Patient: _____ Policyholder's Employer: _____

Policy ID#: _____ Group #: _____

Person to Notify in Case of Emergency:

Name: _____ Relationship to Patient: _____

Address: _____ Home #: _____ Cell #: _____

Please give photo ID and insurance card(s) to receptionist for copying.

Authorization: My signature indicates that I have read the above and grant authorization of treatment and am responsible for payment of fees. I also authorize the release of any medical information requested by my insurance carrier and authorize payment of medical benefits to the physician. Photostat of the above is as valid as original.

Patient or Parent/Guardian Signature: _____

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Name: _____

Primary Care Physician: _____

Referring Physician: _____

Chief compliant: In a few words, please describe the reason for your visit today (examples: neck pain, back pain, hand numbness, headache, etc...).

_____

Briefly describe how your pain began.

_____
_____
_____

How long have these symptoms been present?

O 0 - 1 week
O 1 - 2 weeks
O 2 - 4 weeks
O 4 - 6 weeks
O 6 - 8 weeks
O 2 - 3 months
O 3 - 6 months
O 6 - 12 months
O 1 - 2 years
O More than 2 years

What makes your symptoms worse?

O Sitting O Laying down O Standing O Walking

Other: _____

What makes your symptoms better?

O Sitting O Laying down O Standing O Walking

Other: _____

Were these symptoms caused by and injury? O Yes O No

At work? O Yes O No

Motor Vehicle Accident? O Yes O No

Is there a lawsuit involved? O Yes O No

Have you had any physical therapy for this problem? O Yes O No

If yes, when? _____

How many times per week? _____

Age: _____ Weight: _____ Height : _____

O Male O Female

Are you currently performing any exercises on your own at home for this problem? O Yes O No

Do you feel you like the pain prevents you from exercising? O Yes O No

Have you had any type of injections in the past for this problem? O Yes O No

If yes, when? _____

What kind? _____

Are you on any blood thinner medication to prevent blood clots, heart attack, stroke or for any other reason? O Yes O No

If yes, which one(s)? _____

Have you been experiencing any fevers or chills? O Yes O No

Have you had any difficulty controlling your bowel or bladder? O Yes O No

Please list all of your medications.

_____
_____
_____

O I am not taking any medication.

Please list all of your allergies.

_____
_____
_____

O I do not have any allergies

Name: _____

Past Medical History

Have you ever had these symptoms or similar symptoms in the past? O Yes O No

Surgical History

Please list any surgeries you have had and their dates.

_____

_____

_____

O I have had no surgery in the past

Work History

Employer: _____

Have you taken time off work because of your current symptoms? O Yes O No

How much? _____

What is your current work status?

O Unemployed
O Full duty
O Light duty

Social History

Are you married? O Yes O No

Do you smoke? O Yes O No

How many packs per day? _____

Do you drink alcohol? O Yes O No

How much? _____

Do you use any recreational drugs? O Yes O No

What type? _____

Family History

Does anyone in your family have the same or similar problem? O Yes O No

Are there any medical problems that run in your family? O Yes O No

Please describe: _____

_____

_____

Patient Statement:

I fully understand and completed and/or reviewed pages 1 and 2 of this history form.

_____ _____

Patient Signature (or signature of responsible party) Date

ConquestMD® Spine Care and Sports Medicine PLLC

Review of systems

Do you have any of the following symptoms or medical problems?

Abnormal Bleeding	O Yes	O No
AIDS/HIV	O Yes	O No
Anxiety	O Yes	O No
Balance Problems	O Yes	O No
Chest Pain	O Yes	O No
Constipation	O Yes	O No
Cough	O Yes	O No
Depression	O Yes	O No
Diabetes	O Yes	O No
Fainting	O Yes	O No
Fever	O Yes	O No
Hepatitis A, B, or C	O Yes	O No
High Blood Pressure	O Yes	O No
Impotence	O Yes	O No
Incontinence of bowel	O Yes	O No
Incontinence of bladder	O Yes	O No
Loss of appetite	O Yes	O No
Mania	O Yes	O No
Muscle Weakness	O Yes	O No
Nausea	O Yes	O No
Numbness of hands	O Yes	O No
Numbness of feet	O Yes	O No
Runny nose	O Yes	O No
Seizure disorder	O Yes	O No
Shortness of breath	O Yes	O No
Skin rash	O Yes	O No
Skin ulcer	O Yes	O No
Sleep disturbance	O Yes	O No
Sore throat	O Yes	O No
Stomach pain	O Yes	O No
Stomach ulcers	O Yes	O No
Suicidal thoughts	O Yes	O No
Swelling in legs	O Yes	O No
Unexplained weight loss	O Yes	O No
Visual disturbance	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Wheezing	O Yes	O No

Please list any other medial problems not described above.

_____

_____

O I have no other medical problems.

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Authorization of Release of Patient Information

Name of Patient: _____ Phone Number: _____

Other Names Used: _____ Date of Birth: _____Social Security Number: XXX-___-_____

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

Patient information is needed for: Continuing medical care

☐ All date(s) of service ☐ Specific date(s) of service: _____

Information to be released:

☐ History & Physical ☐ Emergency Room Record ☐ Face Sheet
☐ Consultation Report ☐ Operative Reports ☐ Discharge Instructions
☐ Radiology Reports ☐ Lab/Pathology Reports ☐ Other: _____
☐ Radiology Images ☐ Discharge/Death Summary

Format Requested For Information to be Provided:

☐ Paper
☐ Electronic Media (Requires 2 Business days; only applies to data stored electronically)

Method of Delivery:

☐ Patient will pick up
☐ Fax to: **ConquestMD Spine Care and Sports Medicine @ (214) 544-9888**
☐ Mail to address listed below:

_____ may release my information to:
(hospital or facility name)

Ainsworth B. Farrell, M.D.
ConquestMD Spine Care and Sports Medicine, PLLC
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I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history , diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records accord Texas Hospital Licensing law.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows: _____

Signature: _____ **Date:**_____
Patient or legally authorized representative

_____ _____
Printed name of patient or legally authorized representative Relationship to patient

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Ainsworth B. Farrell, M.D.

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Financial Responsibility Agreement

_____ **Initial**

I understand and agree that I will be financially responsible for any and all charges not paid by my insurance company for my visit(s). This includes any medical visit , service, lab testing, x-ray (s), and any other screening or diagnostic testiing ordered by the physician or the physician's staff.

_____ **Initial**

I understand and agree that it is my responsibility, and not the responsibility of the physician or the physician's staff, to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EKG or any other screening or diagnostic testing ordered by the physician or the physician's staff.

_____ **Initial**

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual or customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service for all office visits, injections, x-rays, lab testing, and any surgical procedures that have been ordered. Additional surgical procedures cannot be anticipated until surgery has been performed, therefore, there may be additional balance due for those unexpected procedures.

_____ **Initial**

I understand and agree that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company and/or plan. If my insurance company or plan does not recognize the physician or provider I am seeing, it may result in claims being denied, higher deductible or out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

_____ **Initial**

If I am a Worker's Compensation patient, I understand that I am to provide all necessary billing information. I am to provide my date of injury, claim number, adjustor name and contact information, employer information and insurance carrier information including phone and fax numbers. I understand that if my Worker's Compensation claim has been denied, I am responsible for payment in full.

Print Name: _____
(patient or responsible party)

Signature: _____ **Date:** _____
(patient or responsible party)

Notice of Privacy Practices

ConquestMD® Spine Care and Sports Medicine, PLLC

This notice describes how medical information about you may be used and disclosed, how you can get acess to this information, your rights concerning your health information and our responsibilities to protect your health information.

Please review it carefully.

Dear Patient,

Federal law requires ConquestMD Spine Care and Sports Medicine, PLLC (ConquestMD) to make this Notice of Privacy Practices ("Notice") available to all persons and to make a good faith effort to obtain a signed document acknowledging patients' receipt of this Notice. If you have any questions about this notice, please call me at (214) 544-9887.

Thank you,
Privacy Officer
ConquestMD Spine Care and Sports Medicine, PLLC

When is this notice effective?

This notice became effective on October 9th, 2009. ConquestMD reserves the right to change this notice after the effective date. We reserve the right to make the revised notice apply for all health information that we already have about you, as well as any information we receive in the future. We are required to abide by the terms of this notice currently in effect. The current notice is available on our Web site at: www.conquestmd.com

Revised: September 2013

To whom does this notice apply?

This notice applies to:

- ConquestMD's workforce.
- Students and trainees of ConquestMD.
- All departments, clinics and hospitals of ConquestMD.
- Any member of a volunteer group who may help you while you are seeking health care at ConquestMD.
- Physicians who are members of ConquestMD's medical staff.

What are our responsibilities to you?

Your health information is personal. We are required by law to protect the privacy of your health information, to provide you with this notice and will only release your health information and as allowed by law or with special written permission (authorization) from you. We use the minimal amount of health information needed to do our work. Only those who need your health information to provide services are allowed to use it. ConquestMD protects your information whether verbal, on paper or electronic.

How do we use and release your health information?

ConquestMD primarily maintains your health information in a secure electronic format. Your health information created or received by ConquestMD will most often be used, shared or disclosed electronically. The following section explains some of the ways we are permitted to use and release health information without an authorization from you.

Use And Release Of Your Health Information Without Your Authorization:

Treatement Purposes

While we are providing you with health care services, we may need to share your health information with other health care providers or other individuals who are involved in your treatment. Examples include doctors, hospitals, pharmacists, therapists, nurses and labs that are involved in your care. We may provide proof of immunizations to schools for admission purposes with your permission and agreement.

Payment Purposes

ConquestMD may need to share a limited amount of your health information to obtain or provide payment for the health care services provided to you. Examples include:

- **Eligibility.** ConquestMD may contact the company or government program that will be paying for your health care. This helps us determine if you are eligible for benefits, and if you are responsible for paying a co-payment or deductible.
- **Claims.** ConquestMD and businesses we work with share health information for billing and payment purposes. For example, your doctor must submit a claim form to get paid, and the claim form must contain certain health information.

Health-Care Operations Purposes

ConquestMD may need to share your health information in the course of conducting health care business activities that are related to providing health care to you. Examples include:

- **Quality Improvement Activities.** ConquestMD may use and release health information to improve the quality or the cost of care. This may include reviewing the treatment and services provided to you. This information may be shared with those who pay for your care, or with other agencies that review this data.
- **Health Promotion and Disease Prevention.** We may use your health information to tell you about disease prevention and health care options. For instance, we may send you health care information on issues such as women's health, cancer or asthma.
- **Fund-Raising Purposes.** We may contact you for fundraising purposes to support ConquestMD's in its mission to provide quality health care, research and education. You may opt out of receiving fundraising communication. If you do not want ConquestMD to contact you about fund-raising efforts, please notify ConquestMD, Office of Development, P.O. Box 2757, Frisco, TX 75034.
- **Marketing Purposes.** We may use your health information to provide prescription refill reminders or to communicate about your current prescriptions, or to communicate about a health related service or product which is covered by your health plan or about treatment alternatives for your care coordination. No authorization is required if we have a face-to-face communication with you about a service or product or if ConquestMD provides you with a promotional gift of small value.
- **Business Associates.** There are some services provided at ConquestMD through contracts with Business Associates such as medical transcription services and record storage companies. Business Associates are required by Federal law to protect your health information.
- **Audits.** ConquestMD may use or release your health information to make sure that its business practices comply with the law and with ConquestMD policies. Examples include audits involving quality of care, medical bills or patient confidentiality.
- **Students and Trainees.** Students and other trainees may access your health information as part of their training and educational activities at ConquestMD.
- **Business Activities.** We may use or release your health information to perform internal business activities. Examples include business planning, computer systems maintenance, legal services and customer services.

Other Purposes

- **Required By Law.** Sometimes we must report some of your health information to legal officials or authorities, such as law enforcement officials, court officials, governmental agencies or attorneys. Examples include reporting suspected abuse or neglect, reporting domestic violence or certain physical injuries, or responding to a court order, subpoena, warrant or lawsuit request.
- **Public Health Activities.** We may be required to report your health information to authorities to help prevent or control disease, injury or disability. Examples include reporting certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
- **Health Oversight Agencies.** We may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system, or for governmental benefit programs.
- **Activities Related to Death.** Privacy protections do not apply to the medical record 50 years after death. We may be required to release health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death. We may release health information to family members and others who were involved in your care or payment for care after your death.
- **Organ, Eye or Tissue Donation.** In the event of your death, we may release your health information to organizations involved with obtaining, storing or transplanting organs, eyes or tissue to determine your donor status.
- **Research Purposes.** At times, we may use or release health information about you for research purposes. However, all research projects require a special approval process before they begin. This process may include asking for your authorization. In some instances, your health information may be used or released for a research purpose without your authorization.
- **To Avoid a Serious Threat to Health or Safety.** As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe,

in good faith, that such release is necessary to prevent or minimize a serious and/or approaching threat to anyone's health or safety.

- **Military, National Security or Incarceration/Law Enforcement Custody.** We may be required to release your health information to the proper authorities so they may carry out their duties under the law. This may be the case if you are in the military or involved in national security or intelligence activities, or if you are in the custody of law-enforcement officials.

- **Worker's Compensation.** We may be required to release your health information to the appropriate persons to comply with the laws related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

- **Persons Involved in Your Care.** In certain situations, we may release health information about you to persons involved with your care, such as friends or family members. We may also give information to someone who helps pay for your care. You have the right to approve such releases, unless you are unable to function, or if there is an emergency.

- **Notification/Disaster Relief Purposes.** In certain situations, we may share your health information with the American Red Cross or another similar federal, state or local disaster relief agency or authority, to help the agency locate persons affected by the disaster.

- **Directory Information.** Except when you object, the hospitals may share your location and general condition with persons who request information about you by name, and may share all of your directory information with members of the clergy.

When is your written authorization required?

Except for the types of situations listed above, we must obtain your written permission known as an authorization for any other types of releases of your health information. An authorization is required for the sale of your health information or for marketing purposes. An authorization is required for most uses and disclosures of psychotherapy notes. If you provide us with an authorization to use or release health information about you, you may cancel (revoke) that authorization in writing at any time. Any authorization you sign may be cancelled (revoked) by following the instructions described on the authorization form. You may receive more information about this by contacting the Privacy Office at ConquestMD.
Other uses and disclosures of your health information not described in this Notice may be made only with your written authorization, and you have the right to take back (revoke) your authorization.

What are your rights regarding your health information?

ConquestMD wants you to know your rights regarding your health information.

- **Right to Receive This Notice of Privacy Practices.** You have the right to receive a paper copy of this notice at any time. You may obtain a copy of the current notice in all clinical areas or by visiting our Website at www.conquestmd.com.

- **Right to Request Confidential Communications.** You have the right to ask that ConquestMD communicate your health information to you in different ways or places. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home or at a post office box. We will do this whenever it is reasonably possible. You can find out how to make such a request by contacting the Privacy Office.

- **Right to Request Restrictions.** You have the right to request restrictions or limitations on how your health information is used or released. We have the right to deny your request.

- **Paid In Full.** You may request that we not disclose your health information to your health plan if you have paid for a health care item or service in full and paid for the item or service out of your own pocket. We must honor your request to restrict your health information from being disclosed to your health plan for purposes of payment or health care operations unless the disclosure is required by law. You may obtain information about how to ask for a restriction on the use or release of your health information to your health plan by contacting the Privacy Office.

- **Right to Access.** With a few exceptions you have the right to review and receive a copy of your health information. Some of the exceptions include:
  - Psychotherapy notes;
  - Information gathered for court proceedings; and
  - Any information your provider feels would cause you to commit serious harm to yourself or to others.

  To receive a copy of your record, or to direct your health information to be sent to another person chosen by you, call (214) 544-9887. This office will provide you with the necessary forms and assistance. You may request and receive an electronic copy of your electronic record. We may charge you a cost-based fee which may include copying and/or mailing your health record to you. If you are denied access to your health record for any reason, ConquestMD will tell you the reasons in writing. We will also give you information about how you can file an appeal if you are not satisfied with our decision.

- **Right to Amend.** You have the right to ask that ConquestMD's information in your health record be changed if it is not correct or complete. You must provide the reason why you are asking for a change. You may request a change by sending a request in writing to the Privacy Office. This office will provide you with the necessary forms and assistance. We may deny your request if:
  - We did not create the information;
  - We do not keep the information;
  - You are not allowed to see and copy the information; or
  - The information is already correct and complete.

- **Right to a Record of Releases(Accounting).** You have the right to ask for a list of releases of your health information by sending a request in writing to the Privacy Office. Your request may not include dates earlier than the six years prior to the date of your request. If you request a record of releases more than once per year, ConquestMD may charge a fee for providing the list. The list will contain only information that is required by law. This list will not include releases for treatment, payment, health care operations or releases that you have authorized.

- **Right to be Notified of Disclosure of Unsecured Health Information-** You have the right to be notified following a breach of your unsecured health information.

What can you do if you have a complaint about how your health information is handled?

If you believe that your privacy rights have been violated, you may file a complaint with ConquestMD or with the U.S. Secretary of Health and Human Services. To receive help in filing a complaint with ConquestMD, you may contact the Privacy Office at the address at the end of this notice. You will not be denied treatment or retaliated or penalized in any way if you file a complaint.

Privacy Officer Contact Information

Privacy Officer
ConquestMD Spine Care and Sports Medicine, PLLC
P.O. Box 2757
Frisco, TX 75034

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Ainsworth B. Farrell, M.D.

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HIPPA - Consent for Additional uses of Health Information

Patient Name (Print): _____

Additional Uses of Information
Appointment Reminders. Your health information may be used by our staff to send you appointment reminders. If you **do not** want us to contact you via the phone number you have already provided, and/or leave a voice message on those phone numbers, please choose one or more of the following alternate methods for us to use to contact you:

May we leave messages concerning your appointment with anyone at your workplace?

O Yes O No O N/A

May we leave messages on your voicemail at work?

O Yes O No O N/A

May we leave messages on you voicemail at home?

O Yes O No O N/A

If you are over (or under) the age of 18, may we discuss your appointments and/or treatments with your parents?

O Yes O No O N/A

If you are over the age of 18, may we discuss you appointments and/or treatments with your children?

O Yes O No O N/A

If you answered "no" to any of the above, please inform us of your preferred method of contacting you.

_____
_____

Please provide us with names of those persons, if any, with whom we may discuss your appointments and/or treatment:

_____
_____

_____	_____	_____
Signature of Patient (or Person Authorized to Give Informed Consent for the patient)	**Date**	**Time**

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Acknowledgement of Receipt of HIPPA Notice and Privacy Practices

Our medical practice reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices"

_____

Name of Patient (Print)

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient Representative **Date**
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

ConquestMD®
Spine Care and Sports Medicine, PLLC

Ainsworth B. Farrell, M.D.
6850 TPC Drive - McKinney, TX 75070 - phone: (214) 544-9887 - fax: (214) 544-9888

Disclosure

The physician you are seeing may have financial interest in the following facilities:

Preferred Imaging
5072 West Plano Parkway
Suite 170
Plano, TX 75093
(972) 248-1924

McKinney Surgery Center
4510 Medical Center Drive
Suite 150
McKinney, TX 75069
(972) 547-1580

Dr. Farrell and the ancillary facilities are committed to providing clinical excellence in a safe and attractive environment for you and your family members both in our office and as part of your ancillary health care. His financial interest in these facilities enables him to have a voice in the ancillary facility's administration and their policies. This involvement helps to ensure the highest quality care for you.

If you would like to choose to have your ancillary health care performed at another facility, please inform the physician or his staff during your visit.

If you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Patient Signature:_____ **Date:** _____

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Notice of Office Policies

Thank you for choosing us for your healthcare needs. We would like to take this time to explain our office policies. Please carefully read and initial the information below.

_____ **Initial**

Office Hours: Our office is open Monday to Friday, 8:00AM to 5:00PM. Lunch is between 12:00PM to 1:00PM. If you should have a medical emergency after hours, please contact our office at (214) 544-9887 and the answering service will contact our Physician. **Medication refills are not handled after 4:00pm or on holidays/weekends and are not considered a medical emergency.**

_____ **Initial**

Insurance: We will file an insurance claim with your insurance company. However, your deductibles and co-payments/co-insurance payments are expected at the time services are rendered. In order to file your insurance claims appropriately, we ask that you keep our office informed of any insurance or address changes during your course of treatment. If you are insured under an HMO, MC, POS or EPO policy, it is your responsibility to obtain a referral from your primary care physician for your initial visit.

_____ **Initial**

Work Related Injuries: It is your responsibility as the employee to provide the Injury Status Report to your employer. Failure to do so may result in claim denial and/or loss of benefits. We will provide information to the Case Manager or Adjuster, including treatment plans and appointment compliance reports.

_____ **Initial**

Appointments: There is a **$25.00** missed appointment fee. It is your responsibility as the patient to contact the office **24 hours** before your appointment if you need to cancel or reschedule your appointment.

_____ **Initial**

Forms: FMLA, Disability, Etc: Forms will be completed within 5 business days. There is a minimum charge of **$25.00** payable to the office due at the time the forms are dropped off at the office.

_____ **Initial**

Prescription Refills: Medication refills are done only during regular office hours. **Refills are not addressed after 4:00pm or on holidays/weekends.** It may take up to 2 business days for your request to be handled.

_____ **Initial**

Medical Records: Our office utilizes Health Mark Group for copying medical records. This service may take up to 7 business days to be completed. There is a **minimum charge of $25.00** for this service. Records to other physicians are done free of charge.

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Acknowledgement of Receipt of Office Policies Notice

By signing below, I acknowledge that I have read and fully understand the office policies of the medical practice.

I understand that the medical practice may amend or revise these policies at any time.

I assume full responsibility for any balance owed after my insurance plan has paid including any supplies or services that are not a covered benefit.

_____

Name of Patient (Print)

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Patient Representative **Date**

(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient