## RELEASE OF RECORD FORM

I consent and authorize Lake Country Family Medicine and any practitioner providing medical goods and services to patient to release information contained in any financial records and/or medical records. Including but not limited to, information concerning communicable diseases, such as Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory results, medical history, treatment progress, and/or any other such information to be transmitted via U.S. mail, facsimile, or other electronic medium. This consent to release medical information is subject to revocation in writing at any time, except to the extent that action has been taken.

**RELEASE FROM:**

**Clinic/Hospital:** ______________________________________________

**Phone:** ______________________________ **Fax:** ______________________________

**Address:** _________________________ **City/St:** ________________ **Zip:** __________

☐ All medical records including labs, radiology, and doctor's notes

☐ Doctor's Notes ☐ Lab only ☐ Others: ______________________________

**RELEASE TO:**

**Provider:** Dr. Yung Chen D.O. Dr. Jill Gramer, D.O.

**Address:** 8465 Boat Club Road, Suite 115 Fort Worth, TX 76179

**Phone:** (817) 260-0535 **Fax:** (817) 984-1448

**Patient Name:** ______________________________ **DOB:** ____________________

**Patient/Parent Signature:** ______________________________ **Date:** ____________________

Lake Country
Family Medicine

## NO – SHOW POLICY

*Effective January 1, 2013*

We understand that there are often legitimate reasons for having to cancel an appointment. We ask that you call in advance if you are unable to keep an appointment as we would like to have the option to offer that appointment to another patient who needs medical care.

By signing below, you acknowledge that failure to provide notice of cancellation will result in a $25 no-show fee for any scheduled appointments. This will be billed to you directly and will not be filed to your insurance. No-show fees must be paid before another appointment can be scheduled. Multiple no-show patients are still subject to dismissal from the practice per office policy.

**I CERTIFY THAT I HAVE READ AND FULLY UNDERSTOOD THE ABOVE NOTIFICATION AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.**

______________________________ ____________________

*Signature of Patient* *Date*

______________________________

*Printed Name*

*If patient is under age 18 or unable to authorize consent:*

______________________________ ____________________

*Signature of Parent or Legal Guardian* *Date*

# PATIENT REGISTRATION INFORMATION

Patient Name: ______________________________ Date of Birth: ____________ Sex: ☐ Male ☐Female

Address: ______________________________________ City: ___________________ Zip: ________

Home #: ____________________ Work #: _____________________ Cell #: ____________________

Social Security #: _______________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race/Ethnicity: ____________________________ Preferred Language: English or ____________________

Local Pharmacy: _________________________ Phone: __________________ Fax: _______________

For Patient Portal Access, email: ____________________________ Appt Reminders: ☐ Voice Message ☐ Text

How you heard about us: ☐ Drive by ☐ Internet search ☐ Through your insurance provider ☐ Former patient ☐ Referred by a patient, name (optional) _____________________ ☐ Other: _____________________

## PRIMARY INSURANCE INFORMATION

☐ Check if patient is subscriber and then skip to step 2. Otherwise, complete steps 1 & 2.
***If patient has Medicaid, patient's parent is the subscriber. Please complete steps 1 & 2***

1. Name of subscriber: ________________________ Date of Birth: _____________ Sex: ☐ Male ☐ Female

Address of subscriber (if different from above): __________________________________________________

Phone # of subscriber: ______________________________ Social Security #: ______________________

Relationship to Patient: ______________________________

2. Name of Primary Insurance Company: ______________________________ Effective Date: ____________

Employer of Subscriber: ___________________________________ Work #: _______________________

Policy/Subscriber ID #: ____________________ Group #: _________________________ Co-Pay: $ _____

## SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

☐ Check if patient is subscriber and then skip to step 2. Otherwise, complete steps 1 & 2.
***If patient has Medicaid, patient's parent is the subscriber. Please complete steps 1 & 2***

1. Name of subscriber: ________________________ Date of Birth: _____________ Sex: ☐ Male ☐ Female

Address of subscriber (if different from above): __________________________________________________

Phone # of subscriber: ______________________________ Social Security #: ______________________

Relationship to Patient: ______________________________

2. Name of Secondary Insurance Company: ___________________________ Effective Date: ____________

Employer of Subscriber: ___________________________________ Work #: _______________________

Policy/Subscriber ID #: ____________________ Group #: _________________________ Co-Pay: $ _____

## EMERGENCY CONTACT- Please provide a phone number other than the ones listed above.

Name: ____________________________ Phone: ___________________ Relationship: ______________

I hereby authorize my insurance benefits to be paid directly to Lake Country Family Medicine. I understand that I am responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all associated costs including collections and attorney's fee. I hereby authorize Dr. Yung Chen, D.O. or Dr. Jill Gramer, D.O. to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Patient/Parent Signature:_________________________________ Date:_______________

## Lake Country Family Medicine

## Authorization Form

Date: ______________________

Patient Name: ______________________________ DOB: ______________________

1. Consent to Treat: The undersigned consents to any examination or medical treatment, and/or services rendered to patient by the physician/provider or their associates, which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science and no guarantees and be given by anyone as to the results that will attained from any diagnosis or treatment.

2. Assignment of benefits/insurance requirements: In consideration of goods and services rendered, I irrevocably assign and transfer to Lake Country Family Medicine to file a claim on my behalf as the same does not impose any contractual obligations upon Lake Country Family Medicine in that I remain responsible for instituting suit within that applicable statute of limitations. I authorize Lake Country Family Medicine to appeal any denial. It is agreed that any condition, including, but not limited to, precertification, pre-authorization, or second opinions shall remain the sole responsibility for patient and/or the patient's family, legal guardian, representative or agent. I authorize the payor listed here in and any other payors to release any and all information requested and/or related to my claim(s) to Lake Country Family Medicine.

3. Financial responsibility: It is agreed that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges use for services rendered, and I agree that all amounts are due upon requested and are payable to Lake Country Family Medicine, and agree to pay all charges incurred. If not a member of an accepted insurance group, fees for services provided must be paid at time they are rendered. It is agreed that should this amount be delinquent and it becomes necessary for the account to be render to any attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all collection expenses. I agreed that if this account results in a credit balance, the credit amount will be applied to any outstanding account, either current or bad debt.

**The undersigned certifies that he/she has read and accepted this authorization form is that patient or parent(s) or legally authorized representative of the patient(s).**

______________________________________________ ______________________

*Signature of patient or patient's legally authorized representative* *Relationship*

# LAKE COUNTRY FAMILY MEDICINE

## History and Physical Form

**Name:** ________________________________ **Date of Birth:** ________________

**Personal Past Medical History:** { } High Blood Pressure, { } Diabetes, { } Heart Disease, { } Hypothyroid, { } Asthma, { } Seasonal Allergies, { } GERD/reflux, { } High Cholesterol, { } Arthritis { } Other:____________________________________________________

**Family Past Medical History:** *Mother* - ________________________________________

*Father* - ________________________________________

**Past *Medical* Surgery History and When?:** ____________________________________

______________________________________________________________________

______________________________________________________________________

**Current Medication (Dose and Frequency):** ____________________________________

______________________________________________________________________

______________________________________________________________________

**Drug/Food Allergies:** _____________________________________________________

______________________________________________________________________

**Social History:** { } Smoker; Packs per day _________ { } Non-Smoker

{ } Former/Quit; How long ago? ______________

{ } Alcohol – if yes, what type? { } Beer { } Wine { } Liquor { } Other

check frequency and indicate amount: { } daily ______ { } weekly ______

{ } monthly ______ { } social ______

{ } Illegal Drugs: ___________________________________________

Occupation: ______________________________________________

Employer: _______________________________________________

# LAKE COUNTRY FAMILY MEDICINE

## PERSONAL REPRESENTATIVE

Patient: ______________________________ Date of Birth: ______________

SS#: ___________________________ Phone: ______________________

Address/Apt #: ___________________________________________________

City-State-Zip Code: ______________________________________________

---

Please recognize ____________________________________________________
(print name/relationship) as my personal representative to receive health information about me.

Please recognize ____________________________________________________
(print name/relationship) as my personal representative to receive health information about me.

Please recognize ____________________________________________________
(print name/relationship) as my personal representative to receive health information about me.

I understand there is a potential for information disclosed to be re-released by me or the recipient of the information. Lake Country Family Medicine may not condition treatment on whether or not you sign this authorization.

I understand that I may revoke this personal representative recognition, in writing, at any time, except to the extent that action has been taken in reliance on it.

Signed: ___________________________ Date: ___________________

Witness: __________________________ Date: ___________________

If not signed by the patient, please indicate relationship to the patient:

- o parent or guardian of minor patient
- o guardian or conservator of an incompetent patient
- o beneficiary or personal representative of deceased patient
- o other (specify) _____________________________

Print Name if not signed by the patient: __________________________

---

*For office use only:*

Date received: ______________/initials: ______________

Date request rescinded, in writing, by the patient: ______________/initials: ______________

## Lake Country Family Medicine

## Notice of Privacy Practice

This note describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. Although, it is necessary to provide certain information about you for your healthcare needs.

This practice uses and disclose health information about you for treatment to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practice. You can request a copy of this notice at any time. For information about this notice or our privacy practices and policies, please contact the compliance officer.

**How we may use and disclose medical information about you.**

**Treatment**

We may use medical information about you to provide you with medical treatments or services. We may disclose medical information about you to hospitals, doctors, nurses, technicians, medical students, pharmacists, medical supply companies, and other healthcare providers who are involved in your care. For example:

Your care may require the involvement of a specialist. When we refer you to a specialist, we will share some of your information with the physician to facilitate the delivery of your care.

**Payment**

We are permitted to use and disclose your medical information to bill and collect payment for services provided to you. For example:

We may complete a claim form, which contains medical information with a description of the medical service provided to you to obtain payment from your insurance company, HMO, or third party.

**Healthcare operation**

We are permitted to use or disclose medical information for the purpose of healthcare operations which are activities that support this practice and ensure the quality of care is delivered. For example:

We may engage the services of a professional to aid this practice in its compliance program. This person will review billing and medical files to insure we maintain our compliance with regulations and the law.

**Appointment reminder, treatment alternatives, and other health-related benefit**

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may also use your demographic information to send you a greeting card.

**Individuals involved in your care**

We may release medical information about you to a family member, friend, and/or guardian who are involved in your medical care.

# LAKE COUNTRY FAMILY MEDICINE

## Acknowledgement of Review of Notice of Privacy Practices

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.

________________________________________

Print Name of Patient/Parent or Legal Guardian

________________________________________

Relationship to Patient

________________________________________

Signature of Patient/Parent or Legal Guardian

__________________________

Date