300 Trophy Club Drive | Suite 300 | Trophy Club, Texas 76262 | Phone: (817) 490-9841 | Fax: (817) 490 9838

Patient Information

Name: _____ Male / Female
Last Name First Name M.I.

Address: _____City: _____State: _____Zip: _____

Age: _____ Date of Birth: _____ Home #: _____Cell #: _____

Work Phone: _____ Employer: _____**Circle your preferred contact number**

Emergency Contact #: _____ Name / Relationship: _____

Social Security #: _____Email: _____

Marital Status: _____

How were you referred to TrueMedicine? _____

Primary Insurance Information

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Is the patient the primary policy holder? Yes / No – If no, please complete the fields below:

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____

Phone #: _____

Secondary Insurance Information

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Address: _____ City: _____ State: _____Zip: _____

Phone #: _____

ACKNOWLEDGMENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ authorize the use and disclosure of my protected health information per the Notice of Privacy Practices.

1. I authorize the use and disclosure of the name of my treating Physician(s), the nature of my treatment, and my projected outcome (collectively referred to as "Limited PHI"- Protected Health Information) in accordance with the terms of this Authorization. I understand that my demographic information (i.e., name, contact information, age, gender, and insurance status), results of laboratory tests, and procedures made available in my medical record, and dates of health care service may also be disclosed pursuant to the Notice of Privacy Practices.
2. I authorize my Physician and/or health care Provider(s) to make the authorized use and/or disclosure of my Limited PHI to institutionally related offices. I understand that my health information may be use to seek payment from my health plan, from other sources of coverage such as other insurers, or from credit card companies that I use for paying services.
3. I understand that my health information may be used as necessary to support the daily activities of TrueMedicine, PA.
4. I understand that my health information may be disclosed to public health agencies as required by law.
5. I understand that once my Limited PHI is used and/or disclosed pursuant to this Authorization, it may no longer be protected by the HIPAA privacy regulations and may be subject to re-disclosure by the recipients.
6. I understand that I do not have to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from TrueMedicine, PA nor will it affect my eligibility for benefits.
7. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed in accordance with the Notice of Privacy Practices.
8. In addition to my treating Physicians and medical facilities, I authorize TrueMedicine, PA to release my records and images to the following individuals: (This should include family or friends responsible for picking up your records when you are unable to do so. Appropriate Identification must be shown to receive records)
   a. Name: _____ Date of Birth: _____
   b. Name: _____ Date of Birth: _____
9. I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me.
10. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of the signature is as valid as the original.
11. I certify that I have received a copy of this authorization. _____ (Initials) *
12. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing as described in the Notice of Privacy Practices. I am aware that my revocation is not effective to the extent that I have authorized the use/or disclosure of my PHI and such use and/or disclosure has been relied upon by authorized recipients.

Patient Signature: _____ Date of Birth: _____

Print Name: _____ Date: _____

If applicable:

Patient Representative: _____ Relationship to Patient: _____

Representative Signature: _____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

My Authorization:

I authorize the following using or disclosing party:

_____

to use or disclose the following health information.

- ☐ All of my health information
- ☐ My health information relating to the following treatment or condition:

_____

- ☐ My health information covering the period from _____to _____(date)
- ☐ Other: _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____Fax: _____ Email: _____

The purpose of this authorization is (check all that apply):

- ☐ At my request
- ☐ Other: _____
- ☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

This authorization ends:

- ☐ On date: _____
- ☐ When the following event occurs: _____

Patient Rights

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnoses, or treated for HIV, (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use you are specifically authorized to release all health care information relating so such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including diagnosis tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges, or expenses, and any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization, I may fill out a revocation form available at the facility or write a letter to the Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which any time it may no longer be protected under Privacy Laws.
5. I understand that the information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.

_____ _____

Signature of Patient/ Legal Representative Date

_____ _____

If Legal Representative, Relationship to Patient Signature of Witness/ Attorney

PATIENT PAYMENT POLICY TRUE MEDICINE PA

Thank you for choosing us as your primary care provider. We are committed to providing you with compassionate and professional care. Please read our payment policy, ask us any questions you may have, and sign in the space provided.

1. **Insurance.** We participate in most insurance plans. If you are not insured, payment in full is expected at each visit. If you are insured but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.
2. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service.
3. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
4. **Teledoc Phone Visits.** Teledoc visits are available if you are ill and unable to come into the office. This appointment is considered as a virtual visit and will be billed accordingly with a co-payment/deductible collected after your visit takes place.
5. **Nonpayment.** If your account is over 90 days past due, we may refer your account to a collection agency. Please note this disclaimer we are required to give to each patient. I will be responsible for reimbursement of any fees from the collection agency including all costs and expenses incurred during the collection process in order for True Medicine PA or their designated external collection agency. This may include contact by phone/texts or emails using all information that I provided to True Medicine PA.
6. **Missed Appointments.** True Medicine reserves the right to charge for missed appointments not canceled within a reasonable amount of time. Please help us to better serve you by keeping your scheduled appointment. We ask that you call the office ahead of time if you are unable to keep your appointment.
7. **Weekend/After Hours Services.** If Dr. Matthews performs services resulting from a call through the answering service, including refill requests. Your insurance will be billed for an office visit with co-payment due.

I have read and understand the above information

_____ _____

Patient's Printed Name Date

_____

Patient or Responsible Party Signature

Medical History

Patient: _____ DOB: _____

Who was your previous PCP? (So that we may request records if needed):

_____ _____ _____

Name City, State Phone Number

1. **Please Identify any Previous and current medical conditions (Circle all that apply):**

Acid Reflux	Bleeding Disorder	Depression	Hypertension	Seizures
Adult ADD	Blood Clots	Diabetes	Kidney Disease	Skin Disorder
Allergies	Cancer	Diverticulitis	Liver Disease	Thyroid Disorder
Anxiety	Chronic Pain	Heart Disease	Memory Loss	Ulcers
Arthritis	COPD	High Cholesterol	Migraines	Vitamin Deficiency
Asthma	Other: _____			

Additional Info: _____

2. **Please list any prescription medications that you are currently taking:**

Name of Drug	Dose	How Often?

If additional space is needed, please continue on last page

3. **Please List any supplements or Over-the-Counter medications that you take:**

Name	Dose	How Often?

Medical History Cont.

4. Please list any known allergies or previous reaction to medications (List the name and the reaction that followed – such as rash, shortness of breath, vomiting, etc.…)

Name of Medication: **Type of reaction / symptom (nausea, rash, anaphylaxis):**

_____ _____

_____ _____

_____ _____

5. Do you currently use, or have you ever consistently used, tobacco products or illicit substances?

- Cigars, cigarettes, chewing tobacco, snuff? **Y or N**
- Marijuana **Y or N**
- Recreational Drugs **Y or N**

6. Do you drink alcohol? **Y or N**

If yes, what type and how often? _____

7. Are there any significant medical problems in your family?

	Alive?	Cancer	Heart Attack	Diabetes	Bleeding Disorder
Mother					
Father					
Grandmother					
Grandfather					
Sister					
Brother					
Children					

If cancer exists in your family, what type of cancer was diagnosed? _____

Medical History Cont.

8. For female patients, please answer the following:

Do you see a gynecologist for annual well-woman exams? **Y or N**

At what age did you start menses? _____ Age of menopause (if applicable) _____

What was the start date of your last menstrual period? _____

When was your last pap smear? (Mo/Yr) _____

Have you ever had an abnormal pap? Did you require more frequent monitoring or invasive Procedures? **Y or N**

9. Please list any previous surgeries and/or procedures you have had (include injections, Colonoscopy, fracture repair, etc.)

Surgery/Procedure	Date	Hospital/City

10. Have you ever been hospitalized? If yes, when and please describe the reason:

_____

_____

11. Are you currently having any symptoms? If yes, please describe:

_____

_____

12. Please list any other physicians / specialists that you are currently seeing:

Name	Specialty	Date of Last Visit

Medical History Cont.

13. Which pharmacy do you use?

Local Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

Prescription Information for Patients:

- All controlled substance refill requests require a 5-day notice before refill.
- We use electronic prescribing software in order to accurately communicate prescription information, to keep accurate records on your medications (which will help prevent errors at your pharmacy), to prevent delays in filling your prescriptions, and lastly, so that ANY and ALL medications prescribed by our physicians will be screened for interactions with current medications and potential adverse reactions based on your complete medical history.
- If you are prescribed a controlled substance, it is our clinic's policy to collect a urine sample in order to screen for the presence of other medications/substances that are known to complicate treatment plans that use certain controlled substances. Urine Toxicology and/or Saliva Toxicology test results are strictly confidential. Toxicology results must be reviewed before a controlled substance can be prescribed, unless special circumstances exist. Additionally, your physician may require you to have a 'pharmacogenetic' test under certain circumstances – if you require high doses of opioids, if you have ANY episodes of 'over-sedation' while on therapy or if it becomes necessary to switch drug classes in order to control your pain. Toxicology and pharmacogenetic testing samples are collected on site within our clinic and then shipped to a laboratory here in the DFW area. We will, whenever possible, respect your insurance's lab preference, however, it is sometimes necessary to use a lab that is considered Out of Network. Should that occur, and if you have questions about that process, our staff will assist with getting you the appropriate contact information.
- If you have chronic pain and you require chronic opioid therapy, your physician may choose to have you see a pain management specialist. This referral, may be for one visit or for ongoing chronic care of thar condition. This decision depends on several variables.
- If you have chronic pain and you are being managed with chronic opioid therapy (hydrocodone, oxycodone, Percocet, OxyContin etc.), you must agree to use only One pharmacy for controlled substance prescriptions and you must inform the office if you ever change pharmacies. Controlled substances (CII) opioid prescriptions for chronic pain management are issued as 30 day supplies only. It is necessary to have an appointment within one week prior to your next fill date. One of our nurses or medical assistants will perform a pill count in order to document that you are taking the medication as prescribed. This is also done for the purpose of documenting suspicious medication shortages (on the count) or excess numbers – which can indicate that a refill is not needed. Urine toxicology may be ordered at the physician's discretion during follow up appointments.

Please indicate below, with your signature that you have read this information, been offered an opportunity to ask questions, and that you agree to comply with our clinic policy.

_____	_____	_____
Print Name	Signature	Date

If there is any additional information that you feel is important to your overall care here at TrueMedicine, please include those details here:

Physician Notes: