Total Care Family Practice
Evan C. Allen, MD

1701 N Green Valley Pkwy Bldg 5-C
Henderson, NV 89074
PH: (702) 541-8240 Fax: (702) 541-8241

Demographics

Last Name:_____ First Name:_____
What would you like to be called:_____
Marital Status: ☐ Single ☐ Married ☐ Other Gender: ☐ Male ☐ Female DOB:_____
Social Security:_____ Email:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Ph:_____ Cell Ph:_____

Employment status:
☐ Employed ☐ Retired ☐ Unemployed ☐ Other
Patient's Employer:_____ Wk. Phone:_____
Address:_____
City:_____ State:_____ Zip Code:_____

Spouse/Partners Name:_____ Ph:_____
Emergency Contact:_____ **Ph:**_____
Relationship:_____ May we release Medical Information to Emergency Contact:_____

INSURANCE INFORMATION-PRIMARY INSURANCE

Insurance Company: _____
Insured name (as it appears on card):_____
Policy/Member #_____ Group #_____
Are you the policy holder? If not please fill out the following:
Guarantor's Name:_____ Date of Birth:_____

INSURANCE INFORMATION-SECONDARY INSURANCE

Insurance Company: _____
Insured name (as it appears on the card):_____
Policy/Member #_____ Group #_____
Are you the policy holder? If not please fill out the following:
Guarantor's Name:_____ Date of Birth:_____

How did you hear about us:_____
Which pharmacy do you want us to send your prescriptions to: _____

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Medical Information

Problems to discuss today:_____

Medical History: Circle any past or current medical problems

High blood pressure	Diabetes	Heart murmur	Angina	Heart attack
Tuberculosis	Asthma	Pneumonia	Bronchitis	Thyroid disease
Anemia	Glaucoma	Cancer	Osteoporosis	Seizures
Kidney infections	Depression	Headache	Arthritis	Hepatitis

Any other significant medical problems:_____
_____.

Previous surgeries (include dates):_____
_____.

Allergies to medications:_____.

Family member's medical History: Circle any past or current medical problems

High blood pressure	Diabetes	Heart murmur	Angina	Heart attack
Tuberculosis	Asthma	Pneumonia	Bronchitis	Thyroid disease
Anemia	Glaucoma	Cancer	Osteoporosis	Seizures
Kidney infections	Depression	Headache	Arthritis	Hepatitis

When is the most recent you've had the following tests?

Colonoscopy:	Never	1-3months	3-6months	1 year	More than 2 years
Flu Shot:	Never	1-3months	3-6months	1 year	more than 2 years
Physical Exam:	Never	1-3months	3-6months	1 year	more than 2 years
Pneumonia Shot:	Never	1-3months	3-6months	1 year	more than 2 years
Tetanus Shot:	Never	1-3months	3-6months	1 year	more than 2 years
PSA Test:	Never	1-3months	3-6months	1 year	more than 2 years
Yearly fasting labs:	Never	1-3months	3-6months	1 year	more than 2 years
Well Women Exam:	Never	1-3months	3-6months	1 year	more than 2 years

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Do you:

Use of Alcohol: Drinks/Weekly_____ Quit when_____

Use of Caffeine, cups per day: Coffee_____ Tea_____ Soda_____ Energy Drink_____

Use of Tobacco: Never_____ Quit when_____ Current Packs/Day_____

Use of Drugs: Never_____ Quit when_____ Current Packs/Day_____

An Advanced Directive is a legal document (as a living will) signed by a competent person to provide guidance for medical and health-care decisions (as the termination of life support or organ donation) in the event the person becomes incompetent to make such decisions

Do you have an Advanced Directive? _____ Yes _____ No
If you would like one, please discuss at the time of your visit.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

The above information is complete and correct. I authorize release of information necessary to file a claim with my insurance and I assign benefits to Total Care Family Practice. We will gladly file your insurance claim, however payment for co-pays and deductibles are required at the time services are rendered. We cannot guarantee payment to Total Care Family Practice. We have an agreement with you, not your insurance company for payment. In the event your insurance company denies a claim, you will become responsible for services rendered to a minor. If your account is turned over for outside collections, you will be responsible for all costs of the outside collections agency. I authorize release of all medical records to referring and primary care physicians and the insurance company, as applicable. I authorize fax transmission of medical records of necessary.

Signature:_____ **Date:**_____

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Services and Policies

Initial: _____ **Financial and Billing Responsibilities**: All co-payments, co-insurance, deductibles and balances are due at the time of service and will be collected at check-in. We accept cash, credit, and debit cards for payment at check-in. No exceptions will be made. Visits or procedures that are not covered by insurance will be paid at the time of that visit. We provide receipts for every patient. Please ask for a receipt at the time of check-out. You should present your insurance card at each visit. If your insurance status changes you must notify the office immediately or be financially responsible for all services rendered. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. These accounts will be placed with a collection agency and will be subject to all collection and court costs necessary to collect the outstanding balance.

Initial: _____ **Appointment Cancellations:** We require a 24 hours cancellation notice or a $50 fee will be assessed for the office visit. There is a $75 fee for in office procedures and a $175 fee for ultrasound procedures.

Initial: _____ **Late Arrivals:** If you are more than 7 minutes late, your appointment may be rescheduled to a later time or another day. If we have to reschedule you for another day, there will be a $50 same day cancellation fee assessed for that day's reschedule. Because we spend the time needed with each patient visit, we do run behind on occasion. In those situations, we would be happy to reschedule you upon request with no penalty.

Initial: _____ **Refills:** All refill requests will be addressed within 48 hours of receipt of a request form from the pharmacy. This allows time to review your chart notes and respond in an informed manner.

Initial: _____ **Labwork:** Please be aware of the laboratory that your insurance plan uses for blood and tissue samples. If you do not know, please contact your insurance plan and ask them. For your convenience, we can collect all lab specimens in our office. You services will be billed directly from the lab (Quest).

Initial: _____ **Urine Drug Screens:** Our office conducts mandatory urine drug screens on all patients who receive a medication that is labeled by the DEA as a scheduled medication. You are required to pay for the drug screen if it is not covered by insurance.

Initial: _____ **Paperwork Fees:** There is a $20 fee for any form of (1) page that requires a physician signature. If it is more than (1) page, the cost is $50.

Initial: _____ **Authorizations:** It is the goal of every staff member in this office to help facilitate the treatment of each patient. Insurance companies require authorization for procedures and medications. The insurance companies use authorizations as a way to control costs. Each company has different requirements and a separate set of medical necessity guidelines. It is impossible to know every company's policy for each medication and/or procedure. Our office provides the requested information to the insurance company but cannot dictate if it will be approved. Should you have an issue with something not being approved those concerns should be directed to the insurance company.

_____ _____

Name (please print) Signature Date

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Patient Health Information Consent Form

We would like you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning your records. Before we can provide any health care we will require you to read and sign this consent form stating that you understand and agree on how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your health information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

I. I understand and agree to allow Total Care Family Practice to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. I agree to allow Total Care Family Practice to submit requested PHI to my health insurance company (or companies) provided to us by the patient for the purpose of payments. Please be advised that this office will limit the release of all PHI to the minimum.

II. I understand that I have the right to examine and obtain a copy of my own health care records.

III. I understand that this written consent is obtained every six months for all subsequent care given to me in this office.

IV. I understand that I have the right to request to revoke this consent at any time during my care.

V. For your security and rights to privacy, all staff of Total Care Family Practice has been trained in HIPAA regulations and records privacy to enforce those procedures in our office. We have taken all precautions to ensure you that your medical information will not be released to anyone.

VI. I understand that I have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.

VII. I understand if I refuse to sign this consent for the purpose of treatment, payment and health care services, our physicians have the right to refuse services.

In addition, I also give consent to Total Care Family Practice to disclose my protected healthcare information to the following person and/or people:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I fully understand and accept the terms of this consent.

_____ _____
Patient's Name DOB

X_____ _____
Patient Signature Date