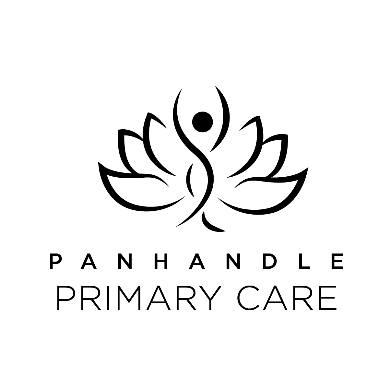
****

**Cindy I Hutson DO PA**

***Patient Information:***

Last Name: First Name: MI:

Address: City: State: Zip:

Home Phone: Cell Phone:

Date of Birth: Gender: M F

Marital Status: Married Single Divorced Widowed

Social Security #: Employer:

Occupation: Full-time / Part-time

Address: City: State: Zip:

Is it okay to leave a message at work? Y N Are you a student? Y N Full-time / Part-time

Work Phone: Ext:

***Spouse Information:***

Last Name: First Name: MI:

Date of Birth: SS#: Phone #:

Employer: Occupation:

Address: City: State: Zip:

***Insurance (Primary) NAME:***

Policy Holder Name:

Policy Holder Birth Date:

Policy Holder Phone #:

Policy Holder SS#:

Relationship to Patient:

***Insurance (Secondary) NAME:***

Policy Holder Name:

Policy Holder Birth date:

Policy Holder Phone #:

Policy Holder SS#:

Relationship to Patient:

***Emergency Contact (Not living in household preferred, but not limited to):***

Name: Phone: Relationship:

Address: City: State: Zip:

**Patient Portal Authorization on the Web**

Panhandle Primary Care offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables patients to communicate with our staff easily, safely, and securely via the internet.

Patients are sent, via email, a secure User ID and password, enabling them to access our secure Patient Portal to view their health records, including in office lab results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

In order to provide you access to the Patient Portal, please provide us your email address or select one of the boxes below:

EMAIL ADDRESS:

I do not have an email address I do not want t access the Patient Portal

I do not want to share my email address Other

**Patient’s Consent to Obtain External Prescription History**

I grant permission to the healthcare providers at Panhandle Primary Care, to view my prescription history from other external sources (other pharmacies and/or providers). I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

Patient or Authorized Person’s Signature Date

Patient’s Printed Name

**FINANCIAL POLICY**

**Panhandle Primary Care**

Welcome to Panhandle Primary Care! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

***PARTICIPATING PROVIDER***

We are providers for several networks and Medicare Part B. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient’s plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list *before* making an appointment.** You will be responsible for payment in full for services rendered by your physician if he/she is not a provider in your plan.

For non-contracted plans, you will need to pay in full and file your own claim.

**YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.**

***CO-PAYMENTS***

We require your co-payment at check-in. We will verify insurance and collect payment based on the information provided by your insurance company.

***DEDUCTIBLE AND COINSURANCE***

If you have a deductible, we will verify insurance and collect payment based on the information provided by your insurance company. We collect deductible, co-insurance and any balance owing at each visit.

***REFERRALS, PRECERTIFICATION, AND PRE-AUTHORIZATIONS***

Referrals, precertification, and pre-authorization of additional medical services is an area in which we strive to help you. Due to the varying policy provisions of all of our patients plans, it is impossible for us to know each patients specific plan provisions. **If you fail to disclose precertification requirements PRIOR to services being rendered, you may be responsible for payment of all related fees in full.**

**IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND INFORM US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN FOR X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.**

***SECONDARY INSURANCE***

We will file secondary insurance as a courtesy to you. Please keep in mind that payment of your account is ultimately your responsibility. We will look to you for payment, if we are unsuccessful in obtaining reimbursement by your insurance.

***RESPONSIBLE PARTY (GUARANTOR)***

The guarantor of the account is the patient who comes in for treatment or the adult who brings in a minor child for treatment, regardless of any court decisions or insurance coverage. If someone other than the guarantor brings a minor child in, that person will be required to pay for services rendered and they will be provided a receipt. It is not the policy of Panhandle Primary Care to become involved in medical bill payment disputes resulting from divorce, etc.

***LIABILITY OR AUTO ACCIDENT CLAIMS***

We do not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on “settlements”. You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed. You may contact our office for a copy of HCFA.

***WORKER’S COMPENSATION CLAIMS***

We do not participate in Worker’s Compensation and are unable to file claims on your behalf. We do not see patients for any work related injuries.

***BILLING OF ACCOUNT BALANCES***

You will receive a statement for which payment is due upon receipt.

***NSF CHECKS***

Checks returned for NSF, will have a $35.00 fee added.

***NON-PAYMENT OF ACCOUNTS***

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.

***CONSULTATION WITH YOUR OWN ATTORNEY:***

AGREEMENT AS TO GOVERNING LAW AND FORUM: The patient and health care provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by the Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas District Court in the county where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state or in any Federal Court. The choice of law and forum selection provisions of this paragraph is mandatory and is not permissive.

**ACCEPTANCE OF FINANCIAL POLICY**

**The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Panhandle Primary Care.**

**Signature of Patient or Legal Guardian Date**

**ASSIGNMENT OF BENEFITS**

**The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to Panhandle Primary Care office provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.**

**Signature of Patient or Legal Guardian Date**

**VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.**

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* effective September 23, 2013 prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below. You can ask for complete Privacy Notice at the front desk.

Patient Name:

(Please Print Name)

Patient Date of Birth:

**SIGNATURES:**

**Please sign if Patient or Legal Representative:**

**Date:**

If Legal Representative, relationship to Patient:

Witness (optional): Date:

Your medical information will not be released to anyone other than yourself or your designated representative. **If you wish for a family member or other representative to have access to your information, please list their names below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

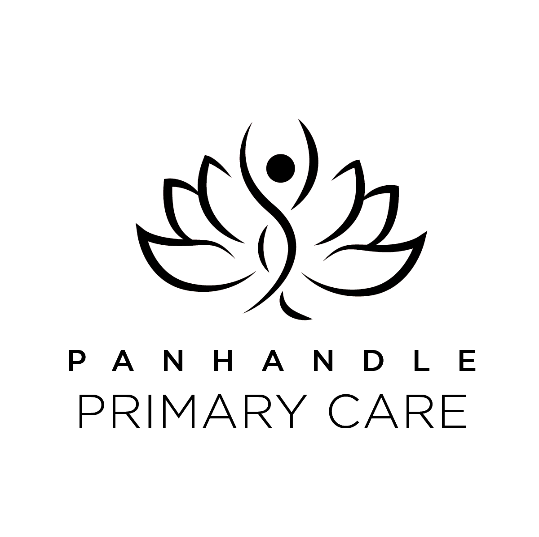
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship

I hereby request the following restrictions for the people listed above, on the use and/or disclosure (specify as applicable) of my information:



Cindy Hutson, DO, PA

2701 S. Georgia

Amarillo, TX 79109

(806)351-2000

FAX (806) 351-2060

Due to the high volume of patients not showing up for their scheduled appointments, we charge a $45.00 fee for no show appointments.

We understand everyone’s schedule is hectic and that changes can arise quickly and unexpectedly. We value your time and will do our best to accommodate your scheduling needs. We appreciate you being considerate of our time and providing advanced notice if you are unable to keep your scheduled appointment so we may accommodate other patients.

Signature of Patient or Legal Guardian Date

**PATIENT NAME:**

**FAMILY HISTORY:** **( list A = alive, if alive and list health history or D = deceased, if deceased and list cause of death ):**

Father (**DOB**): Mother (**DOB**):

Paternal Grandfather: Paternal Grandmother:

Maternal Grandfather: Maternal Grandmother:

**LIST TOTAL NUMBERS BELOW:**

Brothers: = Alive; Deceased Sisters: = Alive; Deceased

Sons: = Alive; Deceased Daughters: = Alive; Deceased

**PLEASE ANSWER (Y = yes or N = no):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Living Will |  | Seatbelts |
|  | Fall Risk |  | Smoke/Vape |
|  | Alcohol |  | Caffeine |
|  | Exercise |  | Recreational Drugs |
|  | Sexually Active |  |  |

**YEAR OF LAST:**

Tetanus Shot: TB Test: Flu Vaccine: Shingles:

Pneumovax: Prevnar 13:

Last Colonoscopy / Cologuard: Due:

Last EGD: Due:

Last Mammogram: Due:

Last Bone Density: Due:

Last Pap (Females Only): Due:

Last PSA/DRE (Males Only): Due:

**Past Surgeries**:

**Specialists that you currently see**:

**Chronic Medical Conditions**:

**LIST ANY DRUG ALLERGIES**: **PHARMACY NAME**: **LOCATION**:

**CURRENT MEDICATIONS: (mandatory – this field must be filled in, include over the counter medications, supplements and vitamins):**

**DRUG NAME DOSAGE AMOUNT HOW OFTEN TAKEN PRESCRIBER**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you a:**

Current Smoker / Vaper

Former Smoker / Vaper

Never Smoked / Vaped

Current every day smoker / vaper

Current some day smoker / vaper

Smoker / Vaper, current status unknown

Unknown if ever smoked / vaped

**If Former Smoker / Vaper: How long has it been since you last smoked?**

1-3 month

<1 month

3-6 months

6-12 months

1-5 years

5-10 years

>10 years

**If current smoker / vaper: How often do you smoke cigarettes**

Everyday

Some days, but not everyday

**If current smoker / vaper: How many cigarettes a day do you smoke?**

5 or less

6-10

11-20

21-30

31 or more

**If current smoker / vaper: How soon after you wake up do you smoke your first cigarette?**

Within 5 min

6-30 min

After 60 min

**If current smoker / vaper: Are you interested in quitting?**

Ready to quit

Thinking about quitting

Not ready to quit

**If current smoker / vaper: When was your last chest x-ray?**