PANHANDLE
PRIMARY CARE

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 with your email address or select one of the boxes below:

EMAIL ADDRESS: _____

☐ I do not have an email address

☐ I do not want 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

Consent for Health Information Exchange – PRISMA

PRISMA is the health information exchange that brings together records from small clinics to large-scale hospital systems whose medical records systems participate in the Carequality and CommonWell health alliance networks. PRISMA also aggregates patient information from insurance payers and patients' wearable devices to promote better interoperability and patient health outcomes.

Initial beside the option of your choice:

OPT IN: Send and Receive Documents

_____ Panhandle Primary Care will send clinical documents when requested by external connected sites (PRISMA) and will also request clinical documents from external connected sites (PRISMA) and display them in our electronic medical records

OPT OUT

_____ Panhandle Primary Care will neither send clinical documents to nor request clinical documents from external connection sites

_____ _____

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.

NSF CHECKS

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

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.

No-Show / Cancelled & Rescheduled Appointments

We ask that you provide us with a 24-hour notice of cancellation or rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of $45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments.

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:

_____

_____

PANHANDLE
PRIMARY CARE

Cindy Hutson, DO, PA

2703 Mockingbird Lane
Amarillo, TX 79109
(806)351-2000
FAX (806) 351-2060

We ask that you provide us with a 24-hour notice of cancellation / rescheduling of any appointments. Any appointments not cancelled / rescheduled within that time period will be subject to a fee of $45.00. This will include cancelled / rescheduled appointments the day of and all no-show / late arrival appointments

Cancellations can be made by:

- **Phone – 806.351.2000 (please leave if message if not during office hours)**
- **Patient Portal (Healow) Message**
- **Email – danaratliff@panhandleprimarycare.com**

ANY QUESTIONS ABOUT CHARGES CAN BE DIRECTED TO
ashleybelter@panhandleprimarycare.com

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? _____