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OLYMPUS FAMILY MEDICINE

Patient Information Update Form

PATIENT INFORMATION

LEGAL NAME: _____
Last First MI

DATE OF BIRTH: _____/_____/_____ SOC SEC #: _____-_____-_____
MM DD YYYY

PREFERRED NAME: _____

CURRENT ADDRESS:

_____
Street Address Apartment Number

_____
City State Zip

Please Indicate Your Preferred Contact Method Below:

- Cell Ph: _____
- Home Ph: _____
- Work Ph: _____
- Email: _____

PARTNER NAME: _____ Marital Status: S M D W
Last First

EMERGENCY CONTACT: _____ Phone # _____
Last First

INSURANCE INFORMATION

Primary Insurance Plan

INSURANCE PLAN NAME: _____ Phone # _____

INSURANCE CARD: Member ID # _____ Group # _____
(Policy Number)

INS. PLAN ADDRESS: _____ Listed PCP: YES NO
Street Address

_____
City State Zip

_____
(If yes, please indicate PCP name)

PRIMARY INSURED'S NAME: _____
Last First MI

PRIMARY'S DOB: ____/____/_____ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: _____
MM DD YYYY

HEALTH INFORMATION

Please indicate any of the following health updates that are applicable or known:

DATE OF LAST ANNUAL WELLNESS EXAM: _____

DATE OF LAST PAP SMEAR/WELL WOMAN: _____

IN THE LAST 6 MONTHS, HAVE YOU HAD ANY OF THE FOLLOWING PERFORMED OUTSIDE OF OUR OFFICE:

____ LABORATORY TESTING ____ RADIOLOGY (X-RAYS/ CT/ MRI/ ULTRASOUND) ____ MAMMOGRAM

____ COLONOSCOPY/ COLOGUARD ____ EKG/ ECG (ELECTROCARDIOGRAM) ____ BONE DENSITY

IF YES, PLEASE INDICATE WHERE: _____

WOULD YOU LIKE OUR OFFICE TO ATTEMPT TO OBTAIN PRIOR RECORDS? YES NO

CURRENT MEDICAL HISTORY/ SOCIAL HISTORY

PLEASE INDICATE ANY CHANGES IN **YOUR** HEALTH FROM YOUR LAST VISIT SUCH AS SURGERIES,

HOSPITALIZATIONS, OR ILLNESSES: _____

_____

_____

HAVE THERE BEEN ANY IMPORTANT CHANGES TO YOUR **FAMILY** MEDICAL HISTORY? YES NO

IF YES, PLEASE INDICATE BELOW:

Relation:	**Medical Condition(s)**:	**Deceased**?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

TOBACCO, ALCOHOL & DRUG HISTORY

RECREATIONAL DRUG USE? ☐ YES ☐ NO

CURRENT TOBACCO USE? ☐ YES ☐ NO

ALCOHOL USE? ☐ YES ☐ NO

IF YES, NUMBER OF DRINKS ON AVERAGE: DAY: _____ WEEK: _____ MONTH: _____

ALLERGIES

Are you **allergic** to any medications or other substances? **Y** ☐ **N** ☐ If yes, please list item and reaction(s) below:

Medication/ Substance Causing Allergy:	Reactions:

CURRENT/ UPDATED MEDICATIONS

Medication	Dosage	Frequency	Reason Prescribed

By signing this form, you acknowledge that all of the information provided above is accurate to the best of your knowledge.

PATIENT SIGNATURE: _____ DATE: _____

OLYMPUS FAMILY MEDICINE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

Olympus Family Medicine is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, heath care operations and as otherwise allowed by the law.

HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than you?

___ **YES**, please release information to the following: ___ **NO**, only release information to me.

Name: _____ **Relationship**: _____

Contact Phone #: _____ **Email**: _____

Name: _____ **Relationship**: _____

Contact Phone #: _____ **Email**: _____

Check which of the following methods we may leave detailed information pertaining to your health:

____ Phone # _____

____ Voice Mail # _____

____ Email (non-encrypted) _____

By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

_____

Print Name of Patient

OLYMPUS FAMILY MEDICINE

Initial All Below **PAYMENT AND PATIENT POLICIES**

x_____ **Co-payments, Co-insurance and Deductibles:** **ALL** co-payments, co-insurance and deductibles MUST be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** most insurance companies require patients to pay a separate Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x_____ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service. It is YOUR responsibility to know your benefits. Please notify the receptionist of any insurance changes when arriving for your appointment. We file your insurance as a courtesy to you. **ALL payments are due at the time of service** including copays, co-insurance, and deductibles.

x_____ ***You are responsible for knowing your insurance policy and benefits.*** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within **90** days of the filing date, YOU will be required to pay the full amount. If we later receive a check from your insurer, we will issue you a refund.

x_____ ***You are responsible for payment of all charges for services NOT covered by your insurance company.*** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim. Medicare patients might have an addition ABN form to sign for potential non-covered services and testing.

x_____ **Billing:** Our billing is out-sourced to W*allace Medical Billing.* Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement. Please call *Wallace Medical Billing* at 1-800-274-7068 for all billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc*.).

x_____ **Delinquent Accounts:** If your account becomes delinquent after 30 days, you will be assessed a $5.00 fee per billing cycle, every 30 days. If payment is not made, your account will be turned over to a collection agency due to delinquency and you will be required to pay all balances in full **before** further services are rendered.

x_____ **Appointments***:* Please arrive 10 minutes before your appointment time to update any changes in contact information or insurance. We require **24** hour notice to cancel or reschedule an appointment. Failure to do so, including late cancellations and missed appointments, will result in a **$50** charge. No-shows will not be tolerated. Patients who repeatedly miss their appointments may have their care terminated with *Olympus Family Medicine*.

x_____ **Laboratory Results and Radiology Results**: In general, all labs and radiology results will be discussed at routine follow up appointments. Routine results are typically available for the provider to review in 5 business days. Some specialty labs can take up to 10 business days. Your provider will determine if you need an appointment or if the results can be discussed over the phone. Results for sexually transmitted disease require an appointment. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered.

x_____ **Call Back Requests***:* The doctor will NOT take calls for non-urgent conditions during regular business hours. Returned calls and messages are typically conducted at the end of the business day; however, the provider will call you within **24 hours.** Please leave a detailed message along with your name, date of birth, and phone number.

x_____ **Medication Refills***:* We require **24** hours for routine medication refills. Please do NOT have the pharmacy fax a refill request to our office. Please do NOT let your medications run out before calling us to request a refill. NO medications will be refilled on weekends. You MUST make an appointment for antibiotics and narcotics.
Narcotics will NOT be prescribed without an appointment.

x_____ **Pharmacy***:* If your insurance company requires you to use a specific pharmacy in order to receive prescription medicine benefits, please notify us. If your insurance company requires prescriptions to be sent from the doctor's office to the mail-order pharmacy, please fill out ALL appropriate forms with the required information and we will fax them to the number you provide.

x_____ **Forms***:* All requests to fill out forms such as FMLA, disability, leave of absence, jury duty exemptions, and others require an office visit. The physician or provider reserves the right to deny signing requested forms.

x_____ **Referrals***:* If you need a referral, we will submit the referral paperwork to a specialist. If the specialist has NOT contacted you within **3 days**, please call us. Before booking an appointment with a specialist, YOU are responsible for checking that the specialist or facility is in-network on your insurance plan. We may send referrals to the physician or facility of your choice. **All HMO's** require a referral BEFORE seeing a specialist and require 72 hours to process.

x_____ **Medical Records***:* Medical records will be released after a signed release is received from the patient. Patients requesting copies of medical records will be charged a base fee of $25.00. ALL medical record requests will be addressed within 10 business days of receipt of both the patient release and payment.

x_____ **Inclement Weather**: In the case of inclement weather, we follow the Frisco ISD policy for closures and delayed openings. We will call you to reschedule your appointment on the first business day we are open.

x_____ **Annual Physicals**: Please allow 8-12 weeks to schedule an annual physical. Two weeks prior to your appointment, please come in for lab work. The focus of an Annual Physical Exam is preventive care. The provider will review your lab work, perform a physical assessment, answer questions, update your treatment plan, and refill maintenance medications for chronic conditions. Acute issues will not be addressed at an Annual Physical appointment. You must schedule a follow-up appointment to discuss those conditions. It is the patient's responsibility to know and understand their insurance coverage. If any services recommended by your provider are not covered under your insurance plan, you must decline the service before it is performed in office. Otherwise, the cost of the denied service will be your responsibility.

Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our above policies.

By signing this form, you acknowledge that you have read and understand all *Olympus Family Medicine's* Patient and Payment Policies listed above.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient