GMA HEALTH

Patient Information

First	Middle	Last	SSN#
Date of Birth		Sex M / F	Marital Status (S/M/D/W)
Mailing Address			
City		State	Zip
Home Phone		Work Phone	Cell Phone
Primary Physician		E-mail Address	Preferred Reminder Method

Parent of legal guardian/guarantor

First	Middle	Last	Relationship
Mailing address (if different from patient)			
Home Phone	Work Phone	Cell Phone	
Date of Birth	Social Security #	Employer	

Emergency Contact

Name	Relationship to Patient	Phone

GMAHealthTX.com

940.521.5500
1339 East Street
Graham, TX 76450

GMA HEALTH

Patient Information

Insurance Information

Primary Insurance	ID#	
Claim Address	Claim Phone	
Insured	Date of Birth	Relationship
Employer Name	Phone	

Secondary Insurance	ID#	
Claim Address	Claim Phone	
Insured	Date of Birth	Relationship
Employer Name	Phone	

Payment in full or copay is expected as service is rendered unless prior financial arrangements have been made. I hereby authorize GMA to submit claims to my health insurance plans, for payment of physician services. I authorize GMA to release any information necessary to process my claims. I also know and agree you file my insurance as a courtesy; therefore, I am ultimately responsible for the balance of my account for any professional services rendered.

Signature	Date

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GMA HEALTH

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____

Date of Birth _____ Social Security No. _____

I authorize the following individual or organization to disclose the above named individuals' heath information:

_____ Address _____

This information may be disclosed TO and used by the following individual or organization:

_____ Address _____

For the purpose of: _____

Please release the following:

_____ Entire Record

OR ____ Problem List
____ Progress Notes
____ History/Physical Exam
____ Medication List
____ Immunization Record
____ List of Allergies

____ X-ray-Imaging Reports from ____ to ____
____ X-ray Films
____ Lab Results from ____ to ____
____ EKG Reports
____ Genetic Testing information
____ Other Diagnostic Reports (Specify)
____ Other (Specify)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ YES, I consent to the release of this information. _____ NO, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to your insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this for in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Michelle Jones, Privacy Officer for Graham Medical Associates.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information of the information contained in these entries. I will not hold Graham Medical Associates, my physician or any other GMA physician liable for any misrepresentation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (if Legal Representative) Witness

Date request completed ____ #Pages Copied ____ Charges $ ____ Cash ____ Check# ____ Reviewed Only ____ Initials

GMA HEALTH

Medical History

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained herein will not be released to any person except when you have authorized to do so.

1. PERSONAL HISTORY

ILLNESS: Have you ever had (Please encircle all answers.)

Emphysema	No	Yes
Heart Attack	No	Yes
Rheumatic Heart Disease	No	Yes
Phlebitis	No	Yes
Kidney Disease or Stones	No	Yes
Prostate Trouble	No	Yes
Jaundice or Hepatitis	No	Yes
Diabetes	No	Yes
Cancer	No	Yes
High Blood Pressure	No	Yes
Hernia	No	Yes
Other Serious Medical Illnesses	No	Yes

If yes, what and when: _____

SURGERY: Have you had previous surgery? No Yes

List: _____ Date: _____

Have you ever been advised to have any surgical operation which has not been done? No Yes

Have you ever been hospitalized for any other illnesses not mentioned above? No Yes

Give Details _____

ALLERGIES: Are you allergic to---

Penicillin	No	Yes
Sulfa	No	Yes
Aspirin, Codeine, or Morphine	No	Yes
Mycins or Other Antibiotics	No	Yes
Any Other Drug	No	Yes
Iodine Compounds	No	Yes
Adhesive Tape	No	Yes
Tetanus Antitoxin or Serums	No	Yes
Latex	No	Yes

DRUGS: List all medications you are taking by name, dosage, and how long you have taken them. _____

2. FAMILY HISTORY

	If Living		If Deceased		Please Encircle		
	Age	Any Illness?	Age At Death	Cause of Death	Has any blood relative ever had		when?
Father					Cancer	No	Yes
Mother					If yes, what kind?		
Brother or Sister 1.					Diabetes	No	Yes
2.					Heart Trouble	No	Yes
3.					High Blood Pressure	No	Yes
4.					Stroke	No	Yes
5.					Other Serious Illness	No	Yes
Husband or Wife							
Son 1.							
2.							
3.							
Daughter 1.							
2.							
3.							

3. HABITS

Do you drink coffee? _____

Tea? _____

Soft Drinks? _____

Chocolate? _____

Alcoholic Beverages Never Rarely Moderate Daily Social

Tobacco

Cigarettes NO YES How many packs per day? _____

Cigars: _____

Pipe: _____

Chewing Tobacco: _____

Snuff: _____

OCCUPATION _____

4. SYSTEMS Do you now have problems with:

Eyes, ears, nose, or throat	No	Yes
Lungs	No	Yes
Heart	No	Yes
Stomach	No	Yes
Colon	No	Yes
Kidneys or Bladder	No	Yes
Liver or Gallbladder	No	Yes
Arteries or Veins	No	Yes
Easy Bruising	No	Yes
Excessive Bleeding	No	Yes

DETAILS _____

Patient Name: _____ DOB: _____ Physician Name: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have been given opportunity to review the "Notice of Privacy Practices" at GMA Health.

Name _____ Birthdate _____

Signature _____ Date _____

SPECIAL INSTRUCTIONS OR LIMITATIONS:

_____

_____

_____

_____

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GMA HEALTH

Financial Policy

*******MUST READ AND SIGN*******

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. There are always ongoing changes in the health care industry, and these changes may affect you in the services that are covered by your insurance carrier, or in services that are determined to be due and payable directly by you.

PATIENT RESPONSIBILITIES AND FINANCIAL POLICIES:

Provide accurate information. You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

KNOW YOUR INSURANCE COVERAGE:

Patients are responsible for understanding their health insurance coverage(s) and benefits. You must present a current insurance card at each visit.

Your health insurance is a contract between you, and your insurance company. As a courtesy to you, we file your claim and the insurance company usually pays us directly. Some services provided to you may not be covered by your insurance. Any disputes with the insurance company should be handled by you.

PATIENT WITH PRIVATE INSURANCE / MEDICARE COVERAGE:

Our physicians participate with most major insurance companies and with the Medicare program. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans in which we do not participate, i.e. there is not a contractual agreement; the practice will expect full payment from the patient at the time of service. It is your responsibility to pay any balance older than 60 days and to follow up with your insurance company for reimbursement. If we receive a payment from your insurance company after your balance has been paid, we will issue you a refund.

CO-PAYMENTS, DEDUCTIBLES, AND FEES:

All co-payments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time service is rendered.

SELF-PAY PATIENTS:

Patients without insurance covered are expected to pay in full for services received at the time of service. We accept cash, checks, money orders, Visa, Master Card, Discover, and American Express. There is a $25.00 charge assessed for all checks returned by your bank not paid and the check will be turned over to the County Attorney's Office after ten business days. A 40% discount is given to self-pay patients only if paid on the day of service. If payment is not rendered on the date of service, you will be billed the full amount of the charges and will be expected to pay the balance before being seen on your next visit.

Revised January 2012

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Occasionally, charges may be added or modified after your visit. For example: your physician may order an additional blood or urine test, or the level of service may be modified per AMA guidelines or by your physician. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due.

MINOR CHILDREN:

The person bringing the child in is responsible for the bill/co-pay for that date of service, regardless of relationship or custody.

PAYMENTS PLANS:

Payment plans on past due patient balances will be considered on a case by case basis. This should be discussed with the billing office. Payment plans may be approved if you can make monthly payments and pay off any outstanding balance within 6 months.

PAST DUE ACCOUNTS:

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service.

PATIENT PAY AGREEMENT

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed "not covered" by my insurance carrier, at the time of service. If my insurance has not paid on my account in 75 days, the outstanding services will be my responsibility for immediate payment (unless Medicare). Should any balanced arise due to insurance co-payments, coinsurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason; I agree to pay all charges within 30 days of service rendered. I understand that failure to pay outstanding balances or make payment arrangements within 60 days will result in the amount due being considered delinquent, at which time collection efforts will be initiated.

NOTICE: Do not sign this agreement before your have read and agree to the conditions set forth above. A copy of the agreement should be kept for your records.

_____ _____

Signature of Patient (or responsible party, if minor) Today's Date

_____

Patient's Date of Birth

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