

Family Care Clinic ePrescribing Consent Form

ePrescribing is now being mandated by Congress for the purpose of providing error free, accurate prescriptions to a pharmacy from a physician. The *Medicare Modernization Act* of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that the Family Care Clinic can request and use your prescription medication history from other healthcare providers and or/third party pharmacy benefit payors for treatment purposes.

 Understanding the above, I hereby provide informed consent to the Family Care Clinic to enroll me in the ePrescribe Program.

Patient’s Printed Name

Patient’s DOB

Patient’s Signature
(Parent’s signature is required for Minors)

Today’s Date



Family Care Clinic
Making families whole...inside and out.
WELCOME!

Patient Registration
Please Print

Patient Information

Patient's Full Legal Name: _____ Race _____
DOB: _____ Age: _____ Sex: M F Marital Status.: S M D W ss# _____
Complete Mailing Address: _____ City: _____ Zip: _____
Complete Residential Address (if different): _____
Cell Phone: _____ Home Phone: _____
Email: _____
In case of emergency, please notify: _____ Phone: _____
Relationship to patient: _____

Fill out this section if patient is not the insurance policy holder.

Name of Insured: _____ Insured's DOB: _____
Insured's SS# _____ Insured's Phone: _____
Insured's Address: _____ City: _____ Zip: _____

Patient's Responsible Party

This section must be filled out if the PATIENT IS A MINOR AND the patient's responsible party is not the insured.

Name: _____
Complete Mailing Address: _____ City: _____
Zip: _____ Home Phone: _____ Other Phone: _____

Responsible Party Agreement

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED, REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE: _____ DATE: _____

Text/Email Message Consent

I hereby give consent to receive text message/email appointment reminders and correspondence from my healthcare provider. I understand that consent is not a condition of receiving service. I understand and agree that any text message I receive may be sent by autodialer.

Phone number to receive text messages: _____ Email: _____

Signature of patient/guardian

Name of patient/guardian

Date

Family Care Clinic
717 W. Lampasas St.
Ennis, TX 75119

Patient Preference Regarding Communication of Health Information

Patient: _____

DOB: _____

I. Who to Contact

I hereby give permission to the Family Care Clinic to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or close personal friend(s):

Name

Relationship

Name

Relationship

Name

Relationship

I DO NOT wish to give permission for family members, relatives, or close personal friends to have access to any information regarding my medical condition.

II. How to Contact

I wish to be contacted in the following manner:

HOME TELEPHONE () -	CELL TELEPHONE () -
<input type="checkbox"/> OK to leave message with detailed information	<input type="checkbox"/> OK to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only
WORK TELEPHONE () -	

Written Communication:
 OK to mail to my home address: _____
 OK to mail to my work/office address: _____
 OK to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of any medical information.

Signature of Patient or Legal Representative

Date

Family Care Clinic
D. Blayne Laws, M.D.
717 W. Lampasas St.
Ennis, TX 75119

CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

Telephone Number: _____ Date of Birth: _____

1. I, _____, (the _____ of _____) hereby voluntarily consent to outpatient care at the office of D. Blayne Laws, M.D., encompassing routine diagnostic procedures, examinations and medical treatment, including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of x-rays, heart tracing, and administration of medications prescribed by the physician.
2. I further consent to the performance of those diagnostic procedures, examinations and Rendering of medical treatment by the medical staff, their assistants, including physician's Assistants or their designees as are necessary in the medical staff's judgment.
3. RELEASE OF INFORMATION: (A) I authorize the clinic to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my (his/her) medical care. (B) I further authorize the release of medical information about medical treatment here to my (his/her) doctor or any designated by me.
4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend(s) the office of D. Blayne Laws, M.D.
5. This form has been fully explained to me, and I understand its contents.

Patient Signature or Signature of
Individual Authorized to Sign for
Patient

Witness

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

Signature of Patient/Guardian

Date

Financial Statement for the Family Care Clinic

Below you will find a list of financial policies for the Family Care Clinic. Please read and sign this statement to affirm that you have read, understand, and agree to these policies.

My policy with my insurance company is a contract between me and my insurance and it is my responsibility to:

1. Bring my insurance card and photo ID with me to every visit. If I do not have an insurance card, I will be considered a cash patient. If I fail to provide new insurance information, I will be responsible for the full balance and it will be my responsibility to file with my new insurance company. No refunds or adjustments will be refunded at a later date.
2. Pay balances in full, or make payment arrangements, before seeing the doctor.
3. Pay my Co-pay at check-in. Pay deductibles or co-insurance at the time of service. I will also be responsible for any services not covered by my insurance or if the claims are not paid in a reasonable amount of time. Post-dated checks will not be held as payment.
4. Pay the full amount due at the time of service if I am a cash pay patient.
5. Pay a \$25.00 cancellation fee if an appointment is not cancelled within 24 hours of the scheduled time.
6. Pay a \$50.00 cancellation fee if an appointment is cancelled less than 12 hours from the scheduled appointment time or if I no show for my appointment.
7. Pay with cash or a credit card. No checks will be accepted on the first visit.
8. Pay a \$25 NSF fee for returned checks.
9. Pay a \$25 late fee applied to any balances after 30 days from the date of the first notice. If I do not pay the balance or make payment arrangements in 30 days from the first notice my account will be turned over to collections and a \$35 fee will apply.

The Family Care Clinic will do their best to understand your benefits for each visit. However, because of the large number of insurance plans we will not be able to know all aspects of each plan.

I have read, understood, and agree to adhere to the policies of the Family Care Clinic.

Signed

Date

Family Care Clinic
D. Blayne Laws, MD

Medication Policies

1. Policies on Controlled Rx:
 - a. Due to the regulated nature of the stimulant/pain medications:
 - i. You will need to see Dr. Laws every 3 months. Exceptions will be made on a case by case basis.
 - ii. Your prescription will be written for 30 or 90 days.
 - iii. For a 30 day RX, 3 prescriptions will be sent with a different “fill by” date. You will need to fill these prescriptions within 30 days of the fill-by date or they will expire. **We will not write a new rx for an expired prescription.**
 - iv. For a 90 day Rx, a new prescription must be written each time.
 - b. We do not refill medications on the weekends or after hours.
 - c. There is a \$10.00 charge if you need the prescription sent to a different pharmacy than the one specified at your appointment.
 - d. If you lose your pills you will need to wait until the next rx fill by date.
2. If you need a medication change for **any reason**, you will need to make an appointment.
3. All patients over 16 years of age will be **drug tested**. If you have a **positive drug test** we will no longer be able to prescribe stimulant medications for your ADD. This includes marijuana. You will be changed a non-stimulant medication.
4. DPS Screening will be done on all patients as required by state law.

I have read, understand, and agree to comply with the above policies.

Name of Patient: _____ DOB: _____

Signature of Patient/Parent of minor: _____

Parent’s name if patient is a minor: _____

Patient History Form

This is a confidential record and will be kept in your doctor's office.
Information contained here will not be released to anyone without your authorization.

Allergies	Type of Reaction	Medical History	Year							
Social History										
Smoking	Yes No									
Alcohol	Yes No									
Street Drugs	Yes No									
Caffeine	Yes No									
Tattoos/Piercings	Yes No									
Exercise	Yes No									
Special Diet	Yes No									
Living Will	Yes No									
Surgical History			Year							
GR ____ PARA ____ AB ____ <input type="checkbox"/> MENARCHE ____ <input type="checkbox"/> MENOPAUSE ____										
Marital Status: <input type="checkbox"/> SINGLE <input type="checkbox"/> Married <input type="checkbox"/> WIDOWED										
<input type="checkbox"/> Deaf <input type="checkbox"/> HOH <input type="checkbox"/> Blind <input type="checkbox"/> VISION IMPAIRED <input type="checkbox"/> Aids for Mobility ____										
Spouse's Name: _____										
Occupation: _____										
Immunizations		Dates								
Influenza										
Diphtheria/Tetanus										
Pneumonia										
PPD										
Family History		Problems								
Relationship										
Mother										
Father										
Maternal GP										
Paternal GP										
Siblings										
Children										
Health Maintenance										
	Date	Results	Date	Results	Date	Results	Date	Results	Date	Results
Annual Exam										
PAP										
Mammogram										
Bone Density										
EKG										
Chest X-ray										
Stress Test										
Echo										
Dopplers										
PSA										
FOBT										
Colonscope/BE										
Eye Exam										
Dental Exam										
Comments/Notes										

PT NAME _____ DOB _____

Provider: _____