PRECISION
FAMILY MEDICINE

Amy C. Murphy, M.D.
Kyle K. Carter, M.D.
John W. Bailey, M.D.

1428 W. Hebron Parkway, Ste 110, Carrollton, Texas 75010 ● Phone 972-939-4555 ● Fax 972-939-7020

AUTHORIZATION OF USE/ DISCLOSURE OF PROTECTED INFORMATION

Appointment reminders: Typically, appointment reminder are brief non-specific message that may be left on your answering machine or text messages sent to you cellular phone.

How would you prefer to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for service provided by Precision Family Medicine. (Check all that apply)

Regular mail_____ Appointment cards_____ Phone/voicemail_____ Fax_____ Email_____

Cell#_____ Work#_____ Fax#_____ Email _____

OK TO LEAVE VOICE MESSAGE-(CIRCLE ONE) **YES** OR **NO**

OK TO SEND TEXT MESSAGE AND EMAILS - (CIRCLE ONE) **YES** OR **NO**

Other Uses and Disclosures: Disclosure of your health information or its use for any purposes other than those listed in the "Notice of Privacy Policies and Practices "consent will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of you health information. **Please list any restrictions below:**

_____

_____

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

_____

Name of person/relation/organization Phone #

_____

Name of person/relation/organization Phone #

_____

Print Patient Name

_____

Signature of Patient Date

_____

Patient Representative Signature/ relationship to patient

PRECISION FAMILY MEDICINE
1428 W. HEBRON PARKWAY, STE 110
CARROLLTON, TX 75010
972-939-4555 (phone) 972-939-7020 (fax)

FINANCIAL POLICY STATEMENT

IMPORTANT INFORMATION PLEASE READ

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT TIME OF SERVICE. For your convenience we accept cash, Master Card, Visa and Discover. Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

As a courtesy to our patients, we will bill contracted insurance plans directly. Any co-payment and/or co-insurance or deductible is payable at the time of service. Payments not received within thirty (30) days of statement date are considered late. Interest on late payments will accrue at a rate of 1.5% monthly. Past due accounts will result in the account being sent to our collection agency. Patient agrees to pay collection cost at an additional 30% of total balance on each account sent to collections. Any patients sent to collections will be dismissed from the practice until the balance is paid in full. No services will be rendered by this office (appointments or prescription refills) until the balance is paid in full.

We do charge to fill out disability or insurance forms, example being FMLA leave, and other forms, this fee **does not** apply to filing your claim with your insurance carrier. Payment of $25 is required prior to our filling out the above mentioned forms. For your convenience we accept cash, Master Card, Visa and Discover. **Those forms not properly signed by the patient will not be filled out. Please allow 3 business days for the completion of these forms.**

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____

Signature of Patient Date

_____

Name of patient (please print)

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PATIENT WAIVER

IMPORTANT INFORMATION – PLEASE TAKE TIME TO READ!

To our Patients:

Many insurance companies today do not cover preventive services (annual physicals, immunizations, screening tests, etc.

We do our best to verify your coverage prior to your visit, **but we cannot guarantee payment of benefits by your insurance plan.** This is a contract between you and your insurance company and it is **YOUR** responsibility to know the terms of your plan.

Some (but not all) of the services that may not be covered by insurance are:

Immunizations: Hepatitis B, Influenza, MMR, Pneumovax, Tetanus

Screening Tests: Cholesterol, Diabetes, Thyroid

Office Visits: Well woman exams, and depression

An annual well woman exam or general physical is preventive in nature and consists of a physical exam, Pap test for women, and **refills of birth control prescription medications**. **These exams are not to be used to treat or discuss any medical problems.** Insurance companies are also very particular that your **annual exam must be scheduled exactly one year from the date of your previous exam. If you schedule your exam too early, it is very likely the insurance will deny payment and you will be responsible for the charges.**

If there is a problem/concern to discuss or treat, then this is not considered a well woman exam or physical and will be billed either as a new or established problem office visit. We are required by insurance company guidelines to submit our bill to your insurance company using accurate information about the type of service you received. **PLEASE DO NOT ASK US TO CHANGE THE CODING OF YOUR VISIT AS THIS IS INSURANCE FRAUD!**

In the event you are referred to a specialist, please keep in mind that the referral is based on quality of care and not insurance acceptance. **It is YOUR responsibility to confirm with the specialist's office to ensure their acceptance of your insurance.**

I understand that I am responsible for full payment to Precision Family Medicine for any services that may not be covered by my insurance plan.

_____ _____

Patient Signature Date

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FAMILY MEDICINE

Amy Murphy, M.D.
Kyle K. Carter, M.D.
John W. Bailey, M.D.
Board Certified Family Medicine

1428 W. Hebron Parkway • Suite100 • Carrollton, Texas 75010 • 972.939.4555 • 972.939.7020

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

PATIENT REGISTRATION FORM

Precision Family Medicine
Amy C. Murphy, M.D.
Kyle K. Carter, M.D.
John W. Bailey, M.D.

1428 W. Hebron Pkwy, Ste 110 Carrollton, Texas 75010 · Phone (972) 939-4555 · Fax (972) 939-7020 · www.pfmed.com

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:		Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Insurance Address	Phone #	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled including Medicare, private insurance, PPO plans, and all other health care plans to Precision Family Medicine, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am fully financially responsible for all charges whether or not paid by said insurance. I hereby authorize and assignee to release all information needed to secure the payment.

Patient/Guardian signature *Date*

Precision Family Medicine

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **April 14, 2003**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including medical information we created or received before we made the changes.

You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We will use and disclose your protected health information about you for treatment, payment, and health care operations.

Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for protected health necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information

in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you by telephone or mail to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact us to request that these materials not be sent to you.

Uses and Disclosures Based On Your Written Authorization: Other uses and disclosures of your protected health information will be made only with your authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.

Marketing: We may use your protected health information to contact you with information about treatment alternatives that may be of interest to you. We may disclose your protected health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Research; Death; Organ Donation: We may use or disclose your protected health information for research purposes in limited circumstances. We may disclose the protected health information of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your protected health information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make

repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your protected health information when authorized by workers' compensation or similar laws.

Process and Proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the protected health information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the protected health information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Patient Rights

Access to Patient Records (Fees & Charges): You have the right to look at, or obtain **copies** of your protected health information, with limited exceptions. You must make a **request in writing** thirty days in advance, to the contact person listed herein to obtain access to your protected health information. You may also request access by sending us a signed letter to the address at the end of this notice. If you request **copies** of written documentation, we will charge you $25.00 for the first 20 pages, then $0.25 cents for each additional page (pursuant to section 375.11 of the Texas Administrative Code) plus postage, if you request the copies be mailed to you. If you request **copies** of off-site records (over two years old) we will charge you $50.00 per hour for staff time to locate and copy your protected health information plus the cost of postage, if you want the copies mailed to you. Copies of x-rays may also be requested **in writing** subject to the same thirty day advance notice for on-site (under two years old) or off-site (over two years old) we will charge you $15.00 for each copy (pursuant to section 375.11 of the Texas Administrative Code) plus the cost of postage, if you want the copies mailed to you. To review only, (no copies made) your protected health information, you must request in writing, thirty days in advance for on-site records and 60 days in advance for off-site records. We will charge you $50.00 per hour for staff time. Any records you receive from Precision Family Med. will be **copies only**, all original records must be kept by the physician's office, (pursuant to 375.11 of the Texas Administrative Code). If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which we, or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2009, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to bill and collect payment from you.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Name of Contact Person: **Kyle K. Carter. M.D.**

Address: **4125 Fairway Dr. Ste. 190 Carrollton, TX 75010**

Telephone: **(972) 939-4555** Fax: **(972) 939-7020**

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MEDICAL HISTORY

Date: _____

Name: _____
Last First Middle

Birth Date: _____ Gender: □ Male □ Female Birth Place: _____

Allergies: _____
_____
_____

Current Medications: _____
_____
_____

Current/Chronic Medical Conditions:
_____
_____
_____
_____

Surgeries: _____
_____
_____
_____
_____

What brings you to our office today:
_____
_____

Do you have any special beliefs that would be important for us to know in regards to your medical care?
_____

Tobacco Use: □ None □ Current Use □ Prior Use Year Started _____Year Quit _____ Amount _____

Alcohol Use: □ None □ Occasional use □ Weekly □ Daily # per week _____

Drug Use: □ None □ Yes Type: _____ How often: _____

Drug Supplements (Any vitamins or over the counter drugs taken on a regular basis): _____
_____

Martial Status: □ Single □ Married □ Divorced/Separated □ Widowed □ Other

Do you have Children? Y/N Number, Name and Age: _____
_____
_____

Are you currently employed? □ Yes □ No Employer: _____

Name: _____ DOB: _____

Last Pap Smear: _____ Last Mammogram: _____

Last Physical Exam: _____ Last Eye Exam: _____

Last Dental Exam: _____ Birth Control Method: _____

For Children ONLY:

_____ _____

Mother's Full Name Date of Birth Father's Full Name Date of Birth

FAMILY HISTORY: ☐ No knowledge of family medical history

Relation	Age	Health Issues	If deceased cause and age
Father			
Mother			
Brothers/Sisters			
Children			

Please indicate medical conditions that run in your family. Please indicate also who is affected by these conditions.

	Asthma :
	Seizures
	Cholesterol:
	Allergies:
	Mental Illness:
	Alcoholism:
	Lung Dis.:
	Diabetes
	Ulcers:
	Kidney Dis.
	Other:
	Cancer:
	Breast::
	Colon:
	Brain:
	Lung:
	Skin:
	Other:

	Headaches:
	Liver Disease:
	Hypothyroid (Low):
	Hyperthyroid (High):
	Heart Attacks:
	High Blood Pressure:
	Stroke:
	Arthritis:
	Reflux:
	Blood Disease
	Heart Disease

How did you hear about us?

_____

_____

_____ _____

Patient Signature Date