LUBBOCK FAMILY MEDICINE

New Patient Profile

Who may we thank for referring you? _____

How did you hear about Lubbock Family Medicine? _____

Patient Information:

_____

Name (Last) (First) (Middle)

_____

Address City State Zip Code

_____

Home Phone Cell Phone Social Security Number

_____

Date of Birth Employer Employer's phone and address

Circle One: Married Single Widowed Divorced Separated

In case of emergency please contact:

_____

Name Phone Number Relationship to patient

General Questions:

Would you like us to call you with reminders about appointments, labs, etc.? **YES | NO**

If so, what is the best time to call you? **MORNING | AFTERNOON | EVENING**

What is the best phone number to reach you? **HOME PHONE | CELL PHONE | WORK PHONE**

Would you like to be added as part of our web enable program? With this program you can make appointments, send messages to the clinic, and confirm your appointments online. **YES | NO**

If **yes**, what is your email? _____

May we contact you after your appointment to evaluate the quality of our clinic services? **YES | NO**

Did you make an appointment for today's visit or did you use our walk-in service? **APPT | WALK-IN**

***If insurance is under someone other than yourself please provide the following information:**

Insured's DOB: _____ Insured's Social Security Number: _____

Authorizations and Agreements for Treatment

The undersigned hereby makes the following Acknowledgements and Agreements regarding treatment to be provided.

1. **Consent to Treatment:** I understand that medical treatment is necessary, and such medical treatment and procedures will be performed by an independent physician, and by the employees in the Clinic. I hereby grant my authorization and consent for such treatment and procedures.
2. **Agreement to Pay for Services:** I acknowledge and accept that no guarantee has been given as to the results these treatments may produce in me. I further acknowledge and accept that any treatment(s) given may not help me and may make my condition worse. For and in consideration of the care and treatment provided to the patient. I promise to pay, or arrange for payment, AT THE TIME OF THIS VISIT all charges due for services rendered to or on behalf of the patient. Payment may be made by cash or credit card.
3. **Consent to Treat by a Physician's Assistant or Nurse Practitioner:** I understand that a Nurse Practitioner or Physician's Assistant that is employed by my physician will visit me. I hereby grant authorization and consent for such treatment.
4. **Assignment and Instruction for Direct Payment to Doctor:** I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:
   (Print the name of your insurance company)

Rodney Franklin, M.D.
Michael Mendez, M.D.
Jamie Stice, FNP
Caitlin Blair, FNP
Rita Mitchell, FNP
Gay Tibbets, FNP
Micah Lust, PA
Patrick Ochoa, FNP
Kobie Benham, FNP

7008 Indiana Avenue, Ste A Lubbock, TX 79413 Phone: (806) 698-8088

If my current policy prohibits direct payment to medical practitioners, then I also instruct and direct you to make out the check to me and mail it directly to:

Rodney Franklin, M.D.
Michael Mendez, M.D.

7008 Indiana Avenue, Ste A Lubbock, TX 79413 Phone: (806) 698-8088

For the professional and medical benefits and otherwise payable to me under my current insurance policy as payments towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THE POLICY. This payment will not exceed my indebtedness to the above-named assignee(s).

Also, I have agreed to pay, in a current manner, the balance due of any and all professional medical service charges over and above any insurance payment. I understand that I am always fully financially responsible for all of these charges.

1. **Release of Medical Information:** I authorize the release of any and all information pertinent to my case to any insurance company, adjuster, or attorney involved in this case who makes the request in writing. I have read and agreed to Lubbock Family Medicine's Privacy Policy. Further, I authorize the release of my medical information to my personal or referral physician.
2. **Risks:** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and or diagnostic procedures planned for me. I realize that common to surgical, medical, and or diagnostic procedures is the potential for infection, blood clots in the veins and lungs, hemorrhage, allergic reactions, failure of treatment, and even death.

I have read the above Acknowledgements and Agreements, and fully understand and Agree to them.

Patient Signature: _____ Witness Signature: _____

Policyholder Signature (if other than Patient): _____ Date: _____

LUBBOCK FAMILY MEDICINE

Privacy Policy Notice

I have read and reviewed Lubbock Family Medicine's Notice of Privacy Policy*. I understand that Lubbock Family Medicine holds my privacy in the highest regards. I also understand that in some situations my medical and billing information will be shared with other parties to provide complete quality medical care. In addition to the parties mentioned in the Notice of Privacy Policies I also consent for Lubbock Family Medicine to share my medical information with those listed below:

☐ Spouse: _____

☐ Other: _____

Signature: _____

*A copy of our Privacy Policy may be obtained at the front desk, please feel free to ask us for one.

LUBBOCK FAMILY MEDICINE

Time-of-Service Payment Policy

Thank you for choosing Lubbock Family Medicine to care for you. We are committed to providing our patients with quality and affordable healthcare. This policy is intended to help our patients understand payment expectations.

Updated 11/22/2019:

- LFM will file a claim to your insurance. However, any payment that is due at the time of service must be collected at your visit. We accept cash, checks, Visa, MasterCard, and Discover.
- LFM will verify benefits and eligibility for all patients prior to their visits. Please be aware that verification of benefits is not a guarantee of payment.
- Copays, deductibles, coinsurance, and non-covered services must be paid in full at the time of your visit.
- Patients may be asked to pay a deposit prior to their visit.
- Qualifying patients will receive a discount at time-of-service.
- Patients are expected to pay previous account balances in full prior to their next visit
- It is the patient's responsibility to know his/her insurance benefits
- It is the patient's responsibility to obtain a referral, if needed, prior to the visit.
- It is the patient's responsibility to provide a copy of the current insurance card at each visit.
- **If your balance remains unpaid, we may refer your account to a collections agency and/or terminate you as a patient.**

I have read and understood the payment policy and agree to abide by its guidelines.

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

LUBBOCK FAMILY MEDICINE

Patient No-Show Policy

At Lubbock Family Medicine, we schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. When you do not show up for a scheduled appointment, you are taking an appointment slot that could have been used for another patient. That's why it is very important that you keep your scheduled appointment with us and arrive on time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us **at least 24 hours notice.**

If a patient does not show-up for an appointment (where the respective patient has not notified LFM in advance) s/he will be charged a **$25 "no-show" service charge** to their account and if it is an **ultrasound patient we will assess a $75 "no-show" service charge** to the patient's account. This "no-show charge" is not reimbursable by the patient's insurance company. The patient will be billed directly for it.

ACKNOWLEDGEMENT

I completely understand Lubbock Family Medicine's Patient No-Show Policy. I acknowledge that if I do not show-up for an appointment (where I have not notified LFM in advance) I will be charged a $25 "no-show" service charge to my account and if it is an ultrasound, I will be assessed a $75 "no-show" service charge to my account.

Patient Name: _____

Patient Signature: _____ Date: _____