This form must be properly completed and signed before you will be allowed to see the doctor.

Legal Name:_____ Age:_____ Date of Birth:_____
Last First Middle

Address:_____ City:_____ ST:_____ Zip:_____
DEA does not recognize P.O Box

Social Security #:_____ Driver's License No:_____ Phone:_____

Cell Phone:_____ Marital Status ❑ M ❑ S ❑ W ❑ D Name of Spouse:_____

Race_____ Language_____ Ethnicity_____ Sex ❑ Male ❑ Female

Email:_____ Employer:_____

Employed: ❑ Full-Time ❑ Part-Time ❑ Retired ❑ Student

Responsible Party:_____
Name Address Phone Relationship

Responsible Party Employer:_____
Name Address Phone

In Case of Emergency:_____
Name Address Relationship

_____
Home Phone Cell Phone

How did you hear about us?_____

Insurance Carrier Name:_____ Group #:_____ Member ID #:_____

Policy Holder Name:_____ Social Security #:_____ Date of Birth:_____

Secondary Carrier Name:_____ Group #:_____ Policy #:_____

Policy Holder Name:_____ Social Security #:_____ Date of Birth:_____

FISCAL POLICY:

1) **Payment is expected at time of service.**
2) All accounts not paid **at time of service** may be referred to a collection agency.
3) We do not get involved in any way with disputes between divorced parents of a child we are treating. If you bring the child for treatment, you are responsible for payment in full for services rendered. **We do not bill the other parent**. We will, however, provide additional copies of your child's bill should you need it.
4) **A $25.00 fee will be charged to the Patient for any appointment that is not cancelled or rescheduled within 24 hours of the scheduled appointment.**

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OR OTHER INFORMATION TO SANDKNOP HEALTH GROUP TO PROCESS INSURANCE CLAIMS OR ANY BENEFITS DUE MY PROVIDER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER AT THIS OFFICE FOR SERVICES RENDERED TO ME. I UNDERSTAND THAT IF THE PHYSICIAN IS NOT PAID IN FULL BY PROCEEDS OF ANY BENEFITS, THEN THIS ASSIGNMENT DOES NOT RELEASE MY OBLIGATION AND LIABILITY TO THE PHYSICIAN FOR PAYMENT OF ALL SERVICES AND ITEMS PROVIDED TO ME.

_____ _____
Signature of Patient OR Patient's Authorized Representative Date

Sandknop Health Group

Office Policies and Financial Responsibilities

Thank you for choosing us as your family physician. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it, ask us any questions that you may have, and sign your approval on Page 2 of this form. A copy will be provided to you upon your request.

- **Privacy Practices:** You will be asked to read and sign notification of our Privacy Practices. You may authorize another individual to receive information about your personal health conditions. Should this be your desire, please execute the Acknowledgement of Receipt of Notice of Privacy Practices form provided.

- **Patient Responsibility:** We participate in many insurance plans. We suggest you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand what **your** policy covers. Please contact your insurance company with any questions you may have regarding your coverage.

- **Physical Address Required:** According to the DEA Guidance policy, CFR 1306.05(a) all patients must have a **physical address** (Not a P.O. Box) on the prescription at the time of dispensing from the practitioner. **Patient's legal full name** is required (as presented on ID or Drivers license). If any of the required elements are incorrect or missing, the prescription will not be issued.

- **Proof of Insurance:** All patients must complete our Patient Information form before seeing the doctor. We must obtain a copy of your valid driver's license and a current, valid insurance card. We may be required to collect payment in full if we are unable to verify your current insurance information. Please bring these items with you to each visit.

- **Co-pay, coinsurance and deductibles:** Pursuant to our participation with your insurance plan, **we are required to collect co-pays, deductibles and coinsurance at the time of service**. We accept cash, checks, Debit Cards, MasterCard, Visa and Discover.

- **Payment at the time of Service: Payment is due at the time of service.** We offer a prompt pay discount of 30% for patients without insurance who are paying for services in full at the time of the visit. **Self-Pay Patients will be required to pay a minimum of $175.00 prior to being seen.**

- **Claims Submission:** If we are contracted with your insurance company, we will file your charges for you. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim.

- **Appointment Cancellation Fee: A $25.00 fee will be charged to the Patient for any appointment that is not cancelled or rescheduled within 24 hours of the scheduled appointment.**

- **Nonpayment:** Unpaid accounts will be referred to an outside collection agency and will be reported to the credit bureau which could result in dismissal from the practice.

- **Returned Checks:** There will be a $35.00 fee for all returned checks.

- **Medical Records and Forms:** Our office follows the rules set forth by the Texas Board of Medical Examiners when preparing and furnishing medical records which allows a fee in the amount of $25.00 for the first twenty pages and $.050 per page thereafter. The fee includes the cost of copying and postage. Payment must be made prior to the release of the records. We ask that you allow 15 business days to process this from the date of the written request. If you require a form or a letter to be completed by the provider (other than return to work/school notes), there will be a charge of $25.00 or more, depending on the length and time required to complete the form.

- **Treatment Disputes:** We do not get involved in any way with disputes between divorced parents of a child we are treating. If you bring the child for treatment, you are responsible for payment in full for services rendered. **We do not bill the other parent**. We will, however, provide additional copies of your child's bill should you need it.

SANDKNOP HEALTH GROUP
1005 W. RALPH HALL PARKWAY, SUITE 221 | ROCKWALL, TX 75032 | 972-771-9000 | 972-771-9002

Consent to Treat, Financial Responsibility & Preferred Method of Communication

Patient Name *(please print)* **Date of Birth**

Consent to Treat

I hereby authorize employees and agents of Sandknop Health Group (including physicians, physician assistants, nurse practitioners and other employees and staff members) to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this Consent, the patient will not be provided medical care except in a case of emergency.

☐ **Initial for Acceptance/Approval** _____

Complete this section ONLY if the patient is a minor

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

☐ **Initial for Acceptance/Approval** _____

Financial Responsibility

I hereby authorize payment of medical benefits directly to Sandknop Health Group and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Sandknop Health Group. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Sandknop Health Group, if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

☐ **Initial for Acceptance/Approval** _____

Signature of Patient, Parent or Legal Guardian **Date**

Sandknop Health Group

HIPAA Permission Update

I have been provided a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand Sandknop Health Group reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

_____ _____
Patient's Printed Name Date of Birth

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Sandknop Health Group to share my protected health information with:

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

_____
Name Relationship Phone

Preferred Method of Communcation

My preferred method of communication regarding my medical conditions is indicated below **(check one)**:

Phone: ☐ Home_____ ☐ Work_____ ☐ Cell _____

If the above method of communication is by phone, please check the appropriate box below **(check one)**:

☐ Leave a message with detailed information. ☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls from the clinic.

☐ **Initial for Acceptance/Approval** _____

_____ _____
Signature of Patient, Parent or Legal Guardian **Date**

Patient Medical History

Name:_____DOB:_____

Please CHECK any illness or condition you have had:

- ❑ ADD
- ❑ Abnormal Pap Smear
- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Back Pain, Chronic
- ❑ Breast Cancer
- ❑ Colon Polyp
- ❑ Depression (current)
- ❑ Depression (past)
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Diabetes, Gestational
- ❑ Diverticular Disease
- ❑ Eczema
- ❑ Endometriosis
- ❑ Erectile Dysfunction
- ❑ Fibromyalgia
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Heart Disease
- ❑ Hemorrhoids
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Irritable Bowel
- ❑ Kidney Stones
- ❑ Low Thyroid
- ❑ Migraine
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Postmenopausal
- ❑ Prostate Enlargement
- ❑ Reflux
- ❑ Rheumatoid Arthritis
- ❑ Seizure Disorder
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Tobacco Use
- ❑ Other_____

Previous Hospitalizations / Surgeries / Serious Illnesses **When?**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History	**Age**	**Diseases**	**If Deceased, Cause of Death**
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Social History

Marital Status_____Occupation_____Tattoos: ❑ Yes ❑ No

Exercise? ❑ Yes ❑ No How Often?_____Substance/Alcohol Abuse? ❑ Yes ❑ No Type?_____

Do you currently smoke? ❑ Yes ❑ No ___Packs/Day___#/Years ❖ Have you ever smoked? ❑ Yes ❑ No ❖ How long since you last smoked?_____

Do you drink alcoholic beverages? ❑ Yes ❑ No ____# per Week ❖ Do you have sexual concerns you want to discuss? ❑ Yes ❑ No_____

Do you have an Advanced Directive? ❑ Yes ❑ No Do you have a Living Will? ❑ Yes ❑ No

Drug Allergies *(include reaction)* **Reaction**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Tdap/Tetanus Booster:_____/_____/_____ Pneumonia Vaccine:_____/_____/_____ Shingles Vaccine:_____/_____/_____ Covid Vaccine:_____/_____/_____

Other Vaccines:_____ _____/_____/_____ _____ _____/_____/_____

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____

Sandknop Health Group

1005 W. Ralph Hall Parkway, Suite 221 | Rockwall, TX 75032 | 972-771-9000 | 972-771-9002 FAX

MEDICAL RECORD RELEASE

Authorization for Release of Information - Must Be Completely Filled Out

SECTION A: Must Be Completed For ALL Authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____Date:_____

SSN:_____DOB:_____

Phone Number:_____Email Address:_____

Medical Provider to release records:	**Persons/organizations receiving the information:**
_____	_____
_____	_____
_____	_____
_____	_____

CHECK TO INDICATE WHICH ITEMS TO RELEASE: Specific Dates *(if applicable)*: from_____to_____

❑ Entire Chart	❑ Labs	❑ Operative Reports	❑ Radiology Report
❑ Progress Notes	❑ Test Results	❑ Consultations	❑ Other Provider Records
❑ Hospital Records	❑ PT Notes	❑ Radiology Films*	❑ Billing
❑ Correspondence	❑ Other:_____		

SECTION B: Must Be Completed ONLY IF A Health Plan/Health Care Provider Requested The Authorization

Will the health plan or care provider requesting the authorization receive financial or any kind of compensation in exchange for using or disclosing the health information described above? ❑Yes ❑No

❑ I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

SECTION C: Must Be Completed For ALL Authorizations - PLEASE READ & INITIAL

What is the purpose of the use or disclosure?_____

X_____ _____

Signature of Patient — Date

X_____ _____

Signature of Patient Representative — Relationship of Patient Representive to Patient