Patient's Name: _____ DOB: ____ / _____ / _____ Today's Date: ____ / _____ / _____

FOSSIL CREEK FAMILY MEDICAL CENTER

Quality Personalized Family Health Care

David Simonak, D.O. Ryan Simonak, D.O. Brady Simonak, D.O.

COMPLETE THESE PAGES AND GIVE TO THE RECEPTIONIST AT FRONT DESK
PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

PATIENT INFORMATION (Please print clearly)

New ☐ Update ☒

SECTION 1: Demographics

Patient's Name: _____ Spouse: _____

Address: _____ Apt#: _____ City: _____

State: _____ ZIP Code: _____ Email_____

Would you like to be web-enabled for easy access to your records, through our secure Patient Portal? Yes ☐ No ☐

Phone: (H)_____ (W)_____ (C)_____

Date of Birth: _____ Age: _____ SSN: _____

Marital Status (Check One): Married ☐ Single ☐ Divorced ☐ Widowed ☐ Sex: Male ☐ Female ☐

Check One: Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Native America ☐ Other _____

SECTION 2: PLEASE COMPLETE SECTION 2 BELOW IF MINOR CHILD UNDER 18

Guardian's Name: _____ Date of Birth: _____ / _____ / _____

Relationship: _____ Phone#_____

Address: _____ City: _____State: _____ ZIP Code: _____

Please list all patients that you are financially responsible for:_____

Patient's Name: _____ DOB: ____ / ____ / _____ Today's Date: ____ / ____ / _____

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SECTION 3: Insured Information

Name: _____ Relationship:_____

D.O.B._____ Phone#_____ Driver's License #: _____ SSN: _____

Address (If Different than Patient): _____

Employer Name: _____ Employer Phone # _____

Employer Address: _____

Primary Insurance Name: _____

ID # _____ Group #: _____

Secondary Insurance Name: _____

ID# _____ Group#:_____

Subscriber's Name: _____ D.O.B.: _____ Relationship:_____

SECTION 4: Allergies

Are You Allergic to Any Medications? Yes ☐ No ☐

If so, please list: _____

SECTION 5: Emergency Contact Information: other than your spouse / child / relative living with you:

Name: _____ Relationship: _____ Phone: (____)_____

7510 N. Beach Street Fort Worth, TX 76137
Phone: (817) 498-1818 **Fax:** (817) 581-3761

Patient's Name: _____ DOB: ____ / _____ / _____ Today's Date: ____ / _____ / _____

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SECTION 6: Please List Your Current Pharmacy

Pharmacy Name: _____ Phone: (____)_____

Address: _____ City: _____ State: _____ ZIP Code: _____

I verify all the information provided above to be correct. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and clinic to release any information needed to process insurance claims or in treatment of my care. I also authorize my insurance claim to be paid directly to the clinic.

_____ _____ _____ / _____ / _____
Signature of Patient / Parent/ Guardian Printed Name Date

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Patient's Initials _____

Patient's Name: _____ DOB: ____ / _____ / _____ Today's Date: _____ / _____ / _____

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PRIVACY RELEASE & ACKNOWLEDGEMENT

Authorization to Leave Messages

_____ (Initial) I authorize Fossil Creek Family Medical Center, P.A. to leave messages regarding my medical condition, such as lab reports, medications, and appointment reminders on my home answering machine.

Authorization to be Contacted at Employment

_____(Initial) I authorize Fossil Creek Family Medical Center, P.A. to contact me and/or leave a message at my place of employment if they are unable to contact me at my home number for any of the reasons listed above. Current Work Phone #: _____

Authorization for Care

_____(Initial) I grant permission for Fossil Creek Family Medical Center, P.A. to render such care that my physician / practitioner may deem necessary in my diagnosis and treatment. Such care may include medical treatment and minor surgical procedures. I also agree, to the best of my ability, to abide by the care recommended by my provider / practitioner.

Authorization for Release of Information

_____(Initial) I authorize Fossil Creek Family Medical Center, P.A. to release necessary information 1) to other physicians for continuing professional care; 2) to any insurance company or third-party payor for the propose of processing a claim; 3) otherwise as allowed by law. I release Fossil Creek Family Medical Center, P.A. from any liability for the release of this information and understand this release includes any and all blood and related test, including HIV, HIB, and other diseases. This authorization is irrevocable and is not limited in time.

Financial Responsibility

_____(Initial) I understand that insurance coverage is not a guarantee of payment, and I agree I am ultimately responsible for payment of services rendered at Fossil Creek Family Medical Center, P.A. I will honor the clinic's payment policy. If I cannot pay in full at the time of service, Fossil Creek Family Medical Center, P.A. can ask others about my credit worthiness. I agree to pay all expenses related to collections, whether by collection agency or by an attorney.

Medicare / Insurance Assignment

_____(Initial) I certify the information I gave in applying for payment of Medicare / Insurance benefits is correct. I irrevocably assign and transfer to Fossil Creek Family Medical Center, P.A. all insurance benefits covering all services provided by an employee / provider of Fossil Creek Family Medical Center, P.A. I understand it is my responsibility to comply with all referral and pre-certification requirements. I acknowledge I am responsible for payment of any insurance deductibles, co-payments, and co-insurance at the time of service.

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PRIVACY RELEASE & ACKNOWLEDGEMENT

RELEASE FORM

Due to the Privacy Law, we need you to list the people that you approve to have access to the following healthcare information when we contact you: (If we may speak with anyone in your household, please note by writing "Anyone" in the appropriate blank, if only self, please indicate such.)

Appointment Scheduling: _____

Billing: _____

Lab Results/Test Results: _____

Prescription/Medications _____

I authorize Fossil Creek Family Medical Center to provide healthcare information concerning me to the following people, should they contact our office. If there is not anyone who might contact us about your private information, please indicate "no one".

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

PRIVACY POLICY

This is to acknowledge I have read and am aware of Fossil Creek Family Medical Center's policy on disclosure of my health information.

_____ I would like a copy of the disclosure of information policies. Given by: _____

_____ I do not choose to obtain a copy of the disclosure of information policies at this time.

I certified that all of the above authorizations will remain in effect unless written notice is given to Fossil Creek Family Medical Center, P.A. to the contrary.

_____ _____ _____ / _____ / _____

Signature of Patient / Parent/ Guardian Printed Name Date

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FINANICAL POLICY AGREEMENT
PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

Fossil Creek Family Medical Center, P.A. is a fee for service facility and the following applies regarding payment:

- If you owe an additional balance after your insurance processes your claim, payment is due within 30 days, unless you make other arrangements.
- We do not accept credit card payments for less than $10.00. Please pay by cash or check.
- If you have authorized another adult to bring your child to our facility, that adult is expected to pay any amount due at the time of service. (It is not our policy to bill parents.)
- If a dependent 18 years of age, or older, is seen by our office without another adult present, they are expected to pay for their services at the time of service. (It is not our policy to bill the parents.)
- If you are divorced, or separated, and you bring your child in, you are responsible for payment and then getting reimbursed by your ex, if they are responsible for payment.
- There is a charge for requesting a copy of your medical records. Payment is expected prior to the record being given to the requesting party. (We will send them to another doctor for your treatment at no charge.)
- There is a charge for the time and effort involved in researching information in your records to complete forms such as disability, FMLA papers, etc. Payment for these is expected prior to the form being released.
- There is a charge for typing letters for any reason. Payment is expected prior to the letter being released.
- There is a return check charge for any check that does not clear the bank, for any reason. (Unresolved returned checks will be referred to the District Attorney for handling.)
- Should you accrue a balance, and payment is not paid within a timely manner, your account will be sent to a collection agency. We will make an effort to notify you prior to being sent for collections. Should your account be sent to a collection agency, you will be responsible for the fees due to the collection agency. These will be added to the balance due, to be paid by you, even if you make payment to our facility, as we are still responsible for issuing payment to the agency.
- Texas is Community Property State; if your spouse owes a balance, you will be liable as well.
- If you would like to give us authorization to charge a credit card for any unpaid balance/balance due, please notify the front office. We will send a receipt for any balance charged.
- A $25 fee will be charged to patients who do not call 24 hours in advance to advise that they will not be able to make their scheduled appointment. This fee will be billed to the patient, as it is NOT COVERED by insurance. The fee must be paid prior to your next appointment. We also reserve the right to terminate patients from the practice who incur multiple "no shows" during a 12-month period.

I have read and agree to abide by the payment policies listed above.

_____ _____ _____ / _____ / _____

Signature of Patient / Parent/ Guardian Printed Name Date

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