VILLAGE HEALTH PARTNERS

Phone: (972) 599-9600

New Patient Forms

village PEDIATRICS

Phone: (214) 473-2200

Patient Information

Mr. Mrs.
Miss Ms. _____ _____
(First, Middle, Last Name) (Date of Birth)

_____ _____
(Address) (City, State, Zip Code)

_____ _____
(Cell Phone Number) (Home Phone Number)

_____ _____
(E-Mail Address) (Preferred Name)

Contact me by(Check all that apply): ☐ Phone ☐ SMS Text ☐ E-Mail

I acknowledge that by choosing any of the above options I give Village Health Partners authorization to contact me via the selected method(s)

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Insurance Information

_____ _____ _____
(Name of Policy Holder) (Date of Birth) (Relationship to Patient)

_____ _____ _____
(Insurance Company) (ID Number) (Group Number)

_____ _____
(Address) (City, State, Zip Code)

Secondary Insurance Information

_____ _____ _____
(Name of Policy Holder) (Date of Birth) (Relationship to Patient)

_____ _____ _____
(Insurance Company) (ID Number) (Group Number)

_____ _____
(Address) (City, State, Zip Code)

A Copy is Available Upon Request

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Responsible Person (If patient is under 18)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

_____
(Phone Number)

Employment Information

_____ _____
(Employer) *(Occupation)*

_____ _____
(Address) *(City, State, Zip Code)*

Employment Status: ◯ **Employed** ◯ **Student** ◯ **Other**

Emergency Contact

_____ _____
(Name) *(Phone)*

_____ _____
(Address) *(City, State, Zip Code)*

_____
(Relationship to Patient)

Pharmacy

_____ _____
(Name) *(Phone)*

_____ _____
(Address) *(City, State, Zip Code)*

How Did You Hear About Us?

- ◯ Searched Online
- ◯ Social Media
- ◯ Flyer
- ◯ Advertisement
- ◯ Online Reviews
- ◯ Event
- ◯ Other
- ◯ Insurance Company Website
- ◯ HR Department
- ◯ Drove By and Saw Location
- ◯ Existing Patient Referral: _____
- ◯ External Provider/Physician Referral: _____
- ◯ VHP or VP Employee/Provider Referral: _____

A Copy is Available Upon Request

VILLAGE HEALTH PARTNERS

village PEDIATRICS

HIPAA Consent and Consent to Treat

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment

Consent to Obtain Prescription History

This consent form authorizes Village Health Partners to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form, you agree that Village Health Partners can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payers (such as your insurance company) for treatment purposes.

Understanding the above, I hereby provide informed consent to Village Health Partners to request, view, and use my external prescription history for treatment purposes.

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice at any time. I have the right to review the notice prior to signing this consent. I have had the opportunity to receive and review the Notice of Privacy Practices of Village Health Partners and Village Pediatrics.

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information

Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient or legal guardian. Please note, in order to share protected health information with your spouse they must be listed as an approved contact.

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

_____ _____

(Name) ***(Date of Birth)***

_____ _____

(Phone) ***(Relationship)***

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

_____ _____

Patient's Name (Please Print) **Patient's DOB**

_____ _____

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

Updated 12.30.2019

VILLAGE HEALTH PARTNERS

village PEDIATRICS

Patient Portal Communication Consent

To sign up for access to your health information through our secure patient portal complete the first portion of this form. To grant access to another adult who helps manage your medical care complete all portions of this form. Patient portal sign up includes FREE access to the following Online Services: lab results, appointment management, prescription refill requests, submitting billing question, referral requests and a medical summary including immunization records.

☐ **YES**, I want VHP to communicate my information with me or those that I grant access to my record through the secure patient portal system that is designed to keep my personal information safe.

Your Information: (All sections required)

Name (last, first, middle initial) _____

Date of Birth: _____ Phone Number: _____

Please provide the email address you would like to use to be notified of secure messages

Email Address: _____

- I understand that I must be 18 years or older in order to be signed up to access my record through the patient portal. If I am under 18 years of age and have become legally emancipated, I must provide legal documentation in order to be provided access to my record through the patient portal.
- I understand that the patient portal is intended as a secure online source of confidential medical information. If I share my user ID and password with another person, that person may be able to view my or my family member's health information.
- It is my responsibility to select a confidential password, to maintain my password in a secure manner, and to change my password if I believe it may have been compromised in any way.
- I understand that the patient portal contains selected, limited medical information from me or my family member's medical record and that it does not reflect the complete contents of my medical record. I also understand that a paper copy of my records may be request ed from the clinic.
- I understand that my activity within the patient portal may become part of my medical record.
- I understand that access to the patient portal is provided by VHP/VP as a convenience to its patients and has the right to deactivate access to the portal at any time for any reason. I understand that use is voluntary, and I am not required to use the portal.
- By signing below, I acknowledge that I have read and understand this Patient Portal Communication Consent and agree to its terms.

_____ _____

Patient Signature **Date**

Grant Patient's Portal Access to Another Adult

Please grant access to my record through the secure patient portal to the following adult who helps to manage my medical care . I understand that all portal communication will be sent to their email/account.

Name (last, first, middle initial) _____

Relationship to Patient: _____

Sex: _____ Date of Birth: _____ Phone Number: _____

Address: _____

Email Address: _____

_____ _____

Patient Signature **Date**

Updated 12.30.2019

VILLAGE HEALTH PARTNERS

village PEDIATRICS

Financial and Office Policies

Initial Below

Thank you for choosing us as your healthcare providers. We are committed to providing you with quality and affordable healthcare. The following are our Financial and Office Policies. Please read, initial on the left, sign at the bottom and return to the front office representative. Please ask us any questions that you may have.

_____ **Patient Responsibility:** We participate in many insurance plans. We recommend 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.

_____ **Insurance Carriers Requiring Referral:** If you are referred to a specialist and your insurance carrier requires a referral number, our office must have at least a 48-hour notice in order to complete that referral.

_____ **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid government issued identification and a current, valid insurance card. Please bring these items with you to each visit. Payment in full is required if we are unable to verify your current insurance information.

_____ **Payments due at the time of service:** Co-pay, deductible, co-insurance

- Cash pay (no insurance) – 30% Prompt Pay Discount
  - The discount includes all charges not covered by an insurance plan, excluding BioTe and Immigration services.
- ***Payment not made at the time of service will incur a $50 processing fee.***

_____ **Nonpayment & Returned Checks:** Unpaid accounts will be referred to an outside collection agency and could result in dismissal from the practice. ***There will be a $30 fee for all returned checks.***

_____ **Late Arrivals:** Please arrive 15 minutes before your appointment. If you arrive late to your appointment, our office may have to reschedule your appointment to a new time or date.

_____ **No shows:** Please notify us 24 hours in advance by phone or secure portal if you must cancel or change your appointment time. ***Failure to do so will result in a $50 no show fee that is not covered by your insurance. A third no show may result in dismissal from the practice.***

- *Please notify us 48 hours in advance by phone if you must cancel or change your imaging appointment time.* ***Failure to do so will result in a $250 no show fee that is not covered by your insurance.***

_____ **Referrals*:*** The physicians of Village Health Partners would advise you that at some point, you the patient may be referred to providers in which a physician or physicians of this practice would receive renumeration for healthcare and services provided. It is the option of the patient to receive ancillary healthcare services from any ancillary healthcare provider or facility of their choice.

_____ **Form completion.** All forms requiring medical review and physician signature – including school, day care, and camp physicals, prior authorizations, FMLA, disability or other paperwork – may be subject to an administrative fee of $30.00. Administrative fees may be waived if the patient has a scheduled appointment in conjunction with formscompletion

_____ **Policy:** I have read and understand the Financial and Office Policies of VHP and agree to abide by its guidelines

www.villagehealthpartners.com www.villagepediatricsplano.com

_____ _____

Signature Date

Updated 12.31.2019

A Copy is Available Upon Request

Patient Medical History

Name:_____ **Date:**_____

Please check any illness or condition you have had:

- ☐ ADD
- ☐ Abnormal Pap smear
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ 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
- ☐ Heart disease
- ☐ Glaucoma
- ☐ 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

SURGERIES

- ☐ Appendix
- ☐ Ear Tubes
- ☐ Gall bladder
- ☐ Heart bypass
- ☐ Hernia repair
- ☐ Knee ACL
- ☐ Knee other
- ☐ Lumbar back
- ☐ Neck C-spine
- ☐ Shoulder
- ☐ Tonsils

Women

- ☐ Breast augmentation
- ☐ C-section
- ☐ Hysterectomy
- ☐ Tubal ligation

Other: _____

Family History (Please include any medical illnesses and cause of death)

Father:_____

Mother:_____

Siblings:_____

Other:_____

Social History

Occupation:_____

Tobacco Use: YES/NO - Type:_____

Alcohol Use: YES/NO - How Often:_____

Exercise: YES/NO - How Often:_____

Routine Health Screening (Most recent Dates)

Colonoscopy: _____

Mammogram: _____

Pap Smear: _____

Bone Density: _____

Tetanus Booster:_____

Medications (Please include "over the counter meds" as well)

Name	Strength	How Often

Drug Allergies (include reaction):_____

Non-drug Allergies (include reaction)**:**_____

Pharmacy Name & Location: _____

VILLAGE HEALTH PARTNERS

CONSENT TO TREAT A MINOR

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

This is a legal document. With it you may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Minor's full name _____ Date of Birth: _____
Last Name First Name Middle Name

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for:

o _____, days only, or

☐ indefinitely, until revoked by written communication.

Please be advised that we will not be able to perform any invasive procedures unless a parent or legal guardian accompanies the minor to their appointment. If such services need to be performed, another appointment will need to be scheduled in which the parent must be in attendance.

It is the policy of this office that the adult presenting the child or the child alone for treatment is responsible for payment of the patient portion at the time of service.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

X_____ _____ _____
Parent's/Guardian Signature Relationship to Patient Date