Boat Club Medical Center Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school _____ City _____ State _____

Patient or parent's employer _____ Work phone _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D.# _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Soc. Security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Ins. Co. address _____ City _____ State. _____ Zip _____

How much is your deductible _____ How much have you used _____ Max annual benefit _____

X _____ _____
Signature of patient (or parent, if minor) **Patient number**

X _____
Signature for release of Medical Records to insurance

BOATCLUB MEDICAL CENTER
3963 BOATCLUB RD.
LAKE WORTH, TX 76135
817-237-8502 Fax: 817-237-8532

CONSENT FOR TREATMENT

- I consent to evaluation, testing, and treatment necessary to the care which has been discussed and directed by the provider.

- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

- I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, it intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

- I further authorize and request that insurance payments be directed to Boatclub Medical Center.

I have read, fully understand and agree to the above medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment and release of medical information & insurance authorization. I also certify that all of the information, provided is complete and accurate.

Patient Name: _____ **Signature:** _____

Date: _____

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FINANCIAL AND PAYMENT GUIDELINES

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Boatclub Medical Center recognizes the need for a clear understanding between patient and medical provider regarding financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning payment for professional services. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Notice: Our office does **NOT** file Auto Insurance claims for visits relating to motor vehicle accidents. Our office does **NOT** treat Workers' Compensation injuries.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

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Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments: Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

SELF PAYMENT: If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

Lab/Diagnostic Services: I understand that I may receive a separate bill if my medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due to these services if they are not reimbursed by my insurance.

- I authorize direct payment of my insurance benefits Boatclub Medical Center for services rendered to myself or dependents.

- Boatclub Medical Center or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

BOAT CLUB MEDICAL
JERRY T. DAVIS D.O.
3963 BOAT CLUB RD
FORT WORTH, TX 76135
817-237-8502 FAX: 817-237-8532

RELEASE OF PATIENT INFORMATION CONSENT FORM

I hereby authorize BOAT CLUB MEDICAL CENTER to release any of my medical information to the following person/persons:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

PATIENT SIGNATURE: _____ DATE _____

PRINT NAME: _____

WITNESS SIGNATURE: _____ DATE _____

Boat Club Medical

MEDICAL HISTORY

Name_____ Age_____ DOB_____ Today's Date_____

Past Medical History Check (√) all that apply:

____Allergies	____Cholesterol	____Gout	____Peripheral Artery Disease
____Anemia	____Chronic Liver Disease	____Hearing Impairment	____Prostate
____Arthritis	____COPD	____Heart Disease	____Psoriasis
____Asthma	____Diabetes	____Heart Failure	____Senile Dementia
____Blindness	____Diabetic Periphheral Neuropathy	____High Blood Pressure	____Stroke
____Cancer	____Diverticulosis	____Incontinence	____TB
____Chemo/Radiation	____Dizziness	____Kidney Stones	____Thyroid
____Carotid Stenosis	____Eczema	____Macular Degeneration	____Ulcers
____Cataracts	____Glaucoma	____Osteoporosis	____Venous Insufficiency/Stasis

Medical Problems:_____

_____

Medications:_____

_____

Allergies:_____

Allergies to Anesthesia? Yes No

Past Surgical History:_____

_____

Past Hospitalizations:_____

_____

OFFICE USE ONLY
Update= √
Date: Initial:

Social History:

Marital Status: M D S W
Monogamous? Y N Homosexual? Y N
No.Children____Residence_____
Live Alone? Y N Retired? Y N
Occupation:_____
Industrial Exposures:_____
Smoker? Y N Packs/day_____
Ex Smoker? Y N Date Quit_____
Alcohol? Y N Drinks/day_____
Mammogram_____
Drugs? Y N_____
Calcium Supp? Y N_____
Dietary HX_____
Exercise_____
Seatbelts used? Y N

Review of Systems √= WNL

HEENT_____
Pulmonary_____
Cardiac_____
GI_____
GU_____
GYN_____
MS_____
Last PAP_____Last
Colonoscopy_____
Dental Exam UTD____Eye Exam UTD_____
Screening Recommended_____
Driver? Y N_____
Flu Vaccine____Last DT____Pneumovax_____

Family History: Mom____Dad____Sibs____

Y N Coronary Artery Disease_____
Y N Hypertension_____
Y N Diabetes_____
Y N Thyroid Disorder_____
Y N Breast Cancer_____Colon Cancer_____
Y N Other_____

Assistive Devices:

Wheelchair_____
Walker_____
Cane_____
Crutches_____
Eyeglasses_____
Hearing Aid_____
Dentures_____

Dr. Jerry Davis, D.O._____ Kasey Murphy, PA-C_____

Boat Club Medical,
Jerry Davis, D.O.
Kasey Murphy, PAC

Tamara Hanby, D.O.,

Scott Hughes, D.O.

Authorization To Release Medical Information

NAME: _____ _____ _____
LAST FIRST M.I.

D.O.B. ____/____/____ **AGE:** _____ **SS#:** _____ **Phone Number:** _____

I, _____, hereby authorize _____
(Name of patient or legal guardian) **(Name of person/entity who should release records)**

Address of person/entity who should release records: _____

Phone Number: _____ **Fax Number:** _____

To release the following information by mail, fax, electronically or orally to Jerry Davis, D.O., Kasey Murphy PAC, Tamara Hanby, D.O., Scott Hughes, D.O.

For the purpose of: ☒ Continue Medical Care ☐ Personal Use ☐ School ☐ Insurance ☐ Legal Purposes ☐ Other: _____

My authorization extends only to those data/elements/documents marked below:

☐ All Records
☐ Statements of Charges or Payments
☐ AIDS or HIV Information
☐ Copies of Records of Reports Provided to the Above
☐ Named (i.e. Hospital, Lab, Clinic, etc.)
☐ Mental Health and/or Alcohol and Drug Abuse Treatment
☐ Progress Notes
☐ Discharge Summary
☐ Consultation Reports
☐ Hepatitis Information
☐ Photographs, Videotapes, Digital, or other Images

☐ **Record of visit for a specific date(s). Specific dates include or are limited to:**

_____
_____
_____

☐ **Other (must be specific):**

_____
_____
_____

This authorization is given freely with the understanding that:
1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Jerry Davis, D.O., Kasey Murphy PAC, Tamara Hanby, D.O., Scott Hughes, D.O., and its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclose by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization

_____ _____
Witness Date

3963 Boatclub Road Lake Worth, TX 76135
817-237-8502 Fax 817-237-8532

YourHealthFile®
Your Portal to a Healthy Life

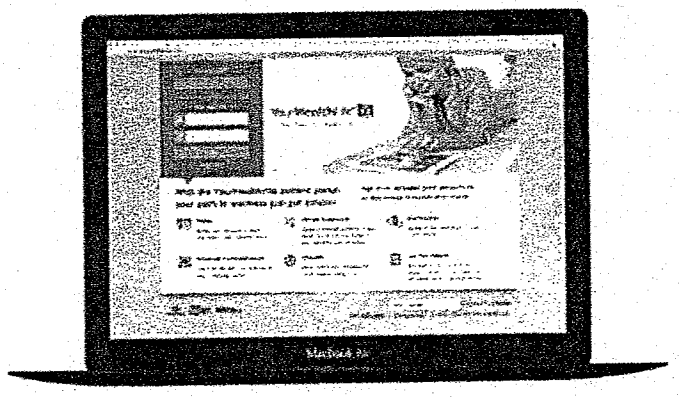
Thank you for being a valued patient. Your path to wellness just got simpler!

We have upgraded our electronic health record software and now have a **new, easy, and secure way** for you to log in to the Patient Portal.

What You Need to Do – Two Simple Options

Email Instructions

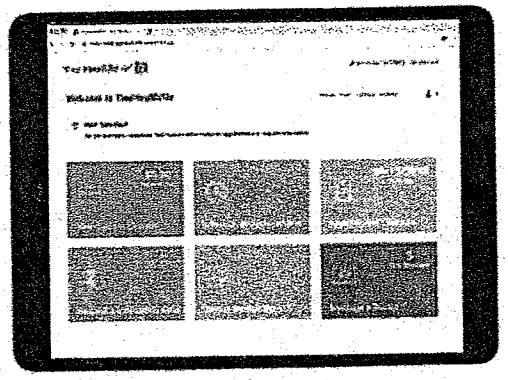
1. Open email and click the registration link (expires in 5 days).
2. Create a username and password.
3. Select and answer a security question.
4. Review and accept the user agreement.
5. Click **Update Account**.
6. Log in with your new username and password.
7. Click **Login**.



Print Instructions

Temporary login credentials expire in 10 days.

1. Go to https://www.yourhealthfile.com.
2. Click **Activate Your Account**.
3. Enter your temporary username and password.
4. Enter your date of birth.
5. Click **Activate Account**.
6. Create a username and password.
7. Enter your email address.
8. Select and answer a security question.
9. Review and accept the user agreement.
10. Click **Update Account**.
11. Log in with your new username and password.
12. Click **Login**.



What You Can Do on Your Portal

- Schedule telehealth visits with your care team
- Review lab results and previous health records
- Update your personal information
- Review patient instructions
- Request appointments
- Make online payments
- Request medication refills
- Securely communicate with your provider
- Fill out information about your visit
- Available in 75 languages

Questions? Call or email our office.