BP: **TEM:** **O2:** **PR:** **RR:** **W:** **H:**

The Beloved Medicine Clinic

7777 Forest Lane, Suite A315
Dallas, TX 75230
P: 972-566-4888

F: 972-534-1308

Today's Date:

New Patient Form

Reason for visit: _____

_____

How did you hear about us? _____

_____

Personal Info:

Name: **First** **Last** **Middle**

_____ _____ _____

Previous Name or Maiden Name _____

Date of Birth: __/__/___ **SSN** _ _ _ - _ _ - _ _ _ _ **PH #**(_____) _____

Email Address _____

Address: Street Number _____ **Street Name** _____

City **State** **Zip**

_____ _____ _____

Employer Name:_____**PH#**(____)_____**Occupation Title:** _____

Insurance Carrier Name: _____

Member ID: _____ **Group Number**_____

Do you have secondary insurance? ❒ **Yes** ❒ **No**

Secondary Insurance Name _____

Member ID: _____**Group Number**_____

Out of Pocket pay:❒ **Yes** ❒ **No** **If yes, how much?** _____

Pharmacy Name _____**PH #**(_____) _____

Address: _____

Emergency contact: **Name:** _____ **PH #** (_____)_____

Relationship _____

Address: _____

Emergency contact #2: **Name:** _____ **PH #** (_____)_____

Patient's name: _____DOB: _____2

Relationship: _____

Address: _____

Previous Medical Conditions (Please check)

❒ Diabetes Mellitus ❒ Congestive Heart Failure ❒ Anemia
❒ Hypertension ❒ Coronary Artery Disease ❒ Cancer Type?_____
❒ Asthma ❒ Thyroid Disease
❒ COPD ❒ Stroke
❒ Other: _____ _____ _____
_____

Previous Surgeries (Please check)

❒ Appendectomy Year? _____ ❒ Cancer Surgery Year? _____
❒ Thyroidectomy Year? _____ ❒ Gallbladder Year? _____
❒ Osteo (Bone) Surgery if so, What Bone? _____
❒ Other: _____ ❒ Other: _____

Family History For Mother (Please check) **Age**_____ Deceased ❒ **Yes** ❒ **No**

❒ Diabetes ❒ High Blood Pressure ❒ Cancer
❒ Stroke ❒ Heart Disease ❒Other:_____
_____ _____

Family History For Father (Please check) **Age**_____ Deceased ❒ **Yes** ❒ **No**

❒ Diabetes ❒ High Blood Pressure ❒ Cancer
❒ Stroke ❒ Heart Disease ❒Other:_____
_____

Family History For (If known) for Grandmother (Please check) Deceased ❒ **Yes** ❒ **No**

❒ Diabetes ❒ High Blood Pressure ❒ Cancer
❒ Stroke ❒ Heart Disease ❒Other:_____
_____

Family History For (If known) for Grandfather (Please check) Deceased ❒ **Yes** ❒ **No**

❒ Diabetes ❒ High Blood Pressure ❒ Cancer
❒ Stroke ❒ Heart Disease ❒Other:_____
_____

Social History:

Smoking: ❒ **Yes** ❒ **No**
-If yes, how many packs per day?_____ For How long?_____
Alcohol: ❒ **Yes** ❒ **No**
-If yes, how many drinks per week? _____ For How long? _____
Drugs: ❒ **Yes** ❒ **No**
-If yes, what kind of drugs? _____
Have you visited any other physicians? ❒ **Yes** ❒ **No**

If so, please indicate below

_____

_____

_____

Medications: Are you on any medications? ❒ **Yes** ❒ **No**

-If yes, please list them below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

*****If you are on other medications, please list them on the back of this page.

****ALLERGIES TO MEDICATIONS:_____

(Note: If you do not have any allergies, Please write "No" in the space provided.)

Would you like a Flu shot today? ❒ **Yes** ❒ **No**

Are you up to date on COVID vaccinations? ❒ **Yes** ❒ **No**

Have you ever had a COLONOSCOPY? ❒ **Yes** ❒ **No**

If yes, what were the findings?_____ When? _____

When was the last dose of COVID vaccine?

Type: Pfizer Moderna J&J.

Booster?

Have you ever had any other preventive tests or scans, ex, doppler, etc?

❒ **Yes** ❒ **No** **If yes, What other Scans? Please List:**

_____ **When?** _____

_____ **When?** _____

_____ **When?** _____

*******For FEMALE patients only:

Last Mammogram date:

Any pertinent findings (mass, cyst,..)?

Last PAP smear date:

Any pertinent findings on previous PAP? (dysplasia, cancer)?

Patient's name: _____DOB: _____4

Patient Consent

I_____ **(print name)**, acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on The Beloved Medicine Clinic (referred to as "TBMC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to me at TBMC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at TBMC consider to be necessary for me. These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my TBMC caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations. I understand that TBMC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription.

Financial Responsibility:

a. Subject to applicable law and the terms and conditions of any applicable contract between TBMC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay TBMC for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below. **Or, b. Subject to applicable law and The Beloved Medicine Clinic self-pay policy, and in consideration of all health care services rendered or about to be rendered to me, I agree to be financially responsible and obligated to pay TBMC for the patient balances due.**

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me, I hereby assign to TBMC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding TBMC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by TBMC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Uses and Disclosures of Health Information: I have received TBMC's Notice of Privacy Practices; The Notice of Privacy Practices explains how TBMC may use and disclose confidential health information that identifies me . I consent to let TBMC use and disclose health information about me as described in the Notice of Privacy Practices. In doing so I consent to the release of my health information and financial account information to all third-party payers and/or their agents that are identified by TBMC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent TBMCor provide assistance to TBMC for the purposes of securing payment from all parties who are potentially liable for payment for my health care, including for substance abuse, psychiatric care, or HIV, if applicable. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to TBMC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from TBMC and its clinical providers, and

Patient's name: _____DOB: _____5

business associates, along with any billing services, collection agencies, agents, or other third parties. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. **. -NEXT PAGE-**

I understand this consent to communications is not required to receive services from TBMC or any of the other authorized callers and that data usage and other charges may apply.I hereby consent and grant to TBMC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by TBMC

I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge TBMC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Patient Printed Name: _____

Patient Signature/responsible party:_____

Today's Date: _____

Please read, initial and sign and date below:
**Explanation of charges that you will get on your bill

1. **Initial visit charge:** In this visit, you get your detailed history, full physical exam, and we order &/or draw blood work, as well as imaging tests, and the doctor comes up with the plan of care. This is usually the highest charge you might see on your bill.
2. **Follow up visits: These are of 2 types;**
    a. **Telephone encounters/video encounters:** the **doctor/staff** will discuss with you your results, and discuss any necessary changes to your plan of care or medications additions/refills. This might include **refill requests, if not done during the time of scheduled visits**. This is a telemedicine/remote encounter that is included in the medical record, and reported to the insurance companies.
    Initial _____
    b. **Physical follow up appointments:** where you come to the office and you get seen by the doctor/Mid-level provider for follow up exam, retesting and possible modification of plan of care.
    Initial _____

During either initial or follow up visit, you might be charged for a **laboratory supply fee of $15.00. This will not be charged to your insurance. It will need to be paid either by cash, check or credit/debit card.**
Please note that we, as a medical clinic, are a **multi-employee facility**, with operational fees, in addition to our affiliate billing company that works with us, charges the insurance, and charges you i.e. they are in charge of the billing; at the same time, the billing company has its own fee as well.
Initial _____
We are committed to an excellent patient care experience. Henceforth, your financial commitment is essential to maintain the quality of the service provided.

Patient statement of financial responsibility:
I _____ hereby declare that I am fully aware of the financial responsibility, as aforementioned, and that I am committed to paying the difference of charges between the insurance payment, and the service charge. I hereby authorize TMBC to charge my credit/debit card with that amount, and/or collect the money via checks, billing statements, or collecting agencies.

Patient's name: _____DOB: _____6

Printed Name _____

_____ _____

Signature of Patient **Date**

Scheduled appointment times are reserved especially for you. If you fail to notify the clinic about any cancellation within 24 hours of your scheduled appointment time, you will be subject to a "No Show/Cancellation" fee of $25.00. The fee will be charged on the card we have on file.

Please note: That your insurance company does not cover these charges.

I understand that the office will make every attempt to place a reminder call for my appointments. However, whether or not a confirmation is placed, I am still responsible for remembering my appointment day and time.

_____ _____

Signature of Patient Date