Bruce E. Maniet
DO, FACOFP
Kelly T. Lewis
MSN, RN, FNP-C

Bells Medical Clinic
PO Box 207
101 S. Broadway
Bells, TX 75414
903-965-7700

Whitewright Family Practice
2016 Beasley Blvd.
Whitewright, TX 75419
903-364-2022

NEW PATIENT INFORMATION

Patient Name: _____ ☐ Male ☐ Female

Mailing Address: _____ Email _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ DOB: _____

Patient SS#: _____ Drivers License #: _____ State: _____

If child, parents name and address

Responsible Party Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ SS# _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

Do you have medical insurance? ☐ Yes ☐No

Subscriber's Name: _____ DOB: _____

SS # _____ Insurance Name: _____

Insurance Phone: _____ Insurance Address: _____

Policy ID Number: _____ Insured's Group Number: _____

Do you have a Co-Pay or Deductible? ☐ Yes ☐No If a deductible then amount $_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If Married Spouse Name: _____

How will you be paying your bill? ☐ Cash ☐ Check ☐ Credit Card (Visa/MC/Discover/AMEX)

Emergency contact Name/Relationship: _____ Phone: _____

What is your chief complaint? _____

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

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Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I, _____

hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to:

Dr. Bruce E. Maniet

This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Signature: _____ Date: _____

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Thank you for choosing our office. You can feel certain you will receive the best quality of care available.

The medical services provided by this office are restricted to the portion of medicine referred to as Family Practice which is the practice of caring for the medical needs of the entire family.

Our office staff will be happy to discuss our fees with you **prior** to you seeing the doctor. We want our patients to understand our fees and feel confident that they are getting the best medical care available for their dollar. Payment in full will be requested for each visit before you leave. If you cannot take care of your bill please see our staff **prior** to seeing the doctor. You will be provided with a detailed itemization of charges at the time of payment for this visit. We suggest you keep this record of your visit which will also indicate that your account is paid n full. At this time you will be given any prescriptions that the doctor deems necessary for your health, and an appointment card as a reminder of any future appointments if needed. Your medical treatment will not be affected by your ability to pay, as your situation will be kept confidential by our staff.

INSURANCE:
We want to reiterate that payment for services received by you or your family members are your sole responsibility. However, as a courtesy to you, we will bill your insurance company and allow 90 days for them to remit payment in full to this office. Should they not respond, deny your claim or fail to pay a portion of the charges, you will be responsible for making full payment within 10 days of their response. You will be responsible for receiving an explanation of benefits from your insurance company. Keep in mind, your insurance policy is a contract between you and that company. Our patients with insurance will be asked to sign an assignment of benefits form before you leave today. This form will ensure that payment will be sent from your insurance provider directly to our office.

LIABILITY INSURANCE PAYMENTS:
If you are involved in litigation against someone fro a wrongful act which brought about your medical needs today, keep in mind that you are still responsible for the payment of your account, not the person you are suing. Since legal matters can often take years to resolve, we ask that you pay your account with us promptly as spelled out in this statement. We will work with your attorney by providing all necessary documentation to him/her for the successful out come of your action, providing the proper fees are taken care of.

MEDICAL RECORDS:
Your medical records are held by this office in strict confidence. They will not be release without your explicit **written** permission. All requests for the release of medical record must be in writing. Since the compilation of these records take time, a reasonable charge must be made for this. A charge of $.20 per page plus appropriate postage will be required for these services, which is not reimbursable by your insurance coverage. This payment will be payable by the person/persons requesting the transfer of medical records be it the patient, insurance company, or other entity.

I have read, understand and agree with the terms listed in the above information.

SIGNED: _____ DATE: _____

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Notice of Privacy Practices Acknowledgement

I understand that, under the health insurance portability and accountability act of 1966 "HIPAA", I have certain rights to privacy regarding my protected health information. In understand that this information can and will be used to:

1. Conduct plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations e.g. quality assessments and physician certifications.

I have read and understand your Notice of Privacy Practices containing a comprehensive description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____
(Self, Spouse, Parent, Guardian, etc.)

Signature: _____

Date: _____

** OFFICE USE ONLY **

I attempted to obtain the patient's signature in acknowledgement of this notice of private practices acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason:

_____

_____