Dr. Osehotue Okojie, M.D. Godwin Okojie, P.A.

Patient Registration Form

(Please Print)

PATIENT INFORMATION

PATIENT'S NAME: _____
Last name First name Middle

Birth Date: ___/___/____ Sex: [ ] M [ ] F Social Security #: ____/___/____

Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

Address: _____
(Number & Street) Apt # City (State/Zip)

Home#:_____ Cell#: _____ Email:_____

Employer: _____
Name Phone

Preferred Pharmacy: _____ Phone #_____

How were you referred to our clinic? [ ] Web/online [ ] Yellow Pages [ ] Employer
[ ] Doctor/Hospital [ ] Friend/Family [ ] Person/other_____

Do you have a living will? Yes No Rx Eligibility Yes/No

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

(Please give your insurance card and id to the receptionist.)

Primary Insurance Name: _____ Subscriber ID #_____

Responsible Party Name: _____Relationship to Patient: _____DOB:___/___/__

Address: _____
(Number & Street) Apt # City (State/Zip)

Secondary Insurance Name: _____ Effective Date: _____

Responsible Party Name: _____Relationship to Patient: _____DOB:___/___/__

AllCare Clinics
Family + Urgent Care

HEALTH HISTORY AND CONSENT FORM

HABITS: 1.Do you smoke?____ If yes, how much?_____ How many years?___ If quit, when?_____
2. Do you drink alcohol?____ If yes, how much? _____If quit, when?_____
3. List other drugs if any_____

LIST all your MEDICATIONS: (Include birth control pill/injection, inhalers, Over the Counter vitamins etc)_____
_____

LIST all your DRUG ALLERGIES:_____
_____

PREVIOUS SURGERIES AND HOSPITALIZATIONS:_____
_____

Reason for today's visit? _____

PREVIOUS/CHRONIC ILLNESSES: (Check each item Yes or No)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Arthritis			Liver Disease			Sleep apnea		
Anemia			Kidney Disease			Headaches		
Allergies			Diabetes			STD		
Asthma/COPD			Thyroid			Cancer		
High B/P			Stroke			Tuberculosis		
Heart disease			Urinary stones			Pneumonia		
Hepatitis			Eczema			Flu Shot		

DISABILITIES (including learning disability) & OTHER ILLNESSES not listed above:_____
_____

FAMILY HISTORY: (Check appropriate boxes)

Family History	Yes	No	If yes, who?	Family History	Yes	No	If yes, who?
Arthritis				Liver Disease			
Thyroid				Stroke			
Diabetes				Kidney Disease			
Asthma/COPD				Cancer			
High B/P				Urinary stones			
Heart disease				Eczema			
Hepatitis				Other:			

FEMALES - OB/GYN History:

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Pain w/ Cycle			Irregular period			Heavy periods		
Discharge			Hot flashes			Sexually active		
Infertility			Yeast infection			Abnormal PAP		

Last Pap:_____ Last mammogram:_____ LMP:_____
#Pregnancies: ___ #Miscarriages:___ #Abortions:___ Stillbirth:___ Natural Birth:____ C-section:_____

Males (50 and Over)
Last Prostate Exam: _____ Abnormal Findings:_____

3825 Ross Avenue Ste 150 Dallas TX 75204 Phone: 214.515.9646 Fax:214.515.9654

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Consent for Medical Treatment

I, the undersigned, consent to the treatment and services which may include, but are limited to laboratory procedures, X-ray, examinations, diagnostic procedures, medical or nursing treatment rendered to me under the general and special instructions of my physician. The consent includes testing for blood borne infectious diseases, including but not limited to hepatitis acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV), if the physician orders such test for diagnostic purposes.

Initial: _____ Disagree_____

Patient Signature: _____ Date:_____

We currently have a Physician Assistant on staff. It is possible that you may be seen by the Physician Assistant instead of a medical Doctor. Please initial here if you agree to allow a Physician Assistant see you, you have the right to decline this.

Initial: _____ Disagree_____

Patient Signature: _____ Date:_____

Notice of Privacy Practices

No later than the first day if service delivery after April 14, 2003 compliance deadline, each patient will be provided with the Notice of Privacy Practices.

Except in emergency situation, AllCare Family and Urgent Care Clinics will make good faith efforts to obtain the patient's written acknowledgment of receipt of this notice (see attached form). If the acknowledgment cannot be obtained, the AllCare staff will document all efforts the acknowledgment and the reason(s) why it was not obtained.

In an emergency treatment situation, the notice will be provided as soon as reasonably practicable to do so after the emergency situation has ended. At the time, AllCare will make good faith effort to obtain written acknowledgment from the patient.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

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 am entitled to receive a copy of this document.

SIGNATURE OF PATIENT OR REPRESENTATIVE:_____

NAME OF PATIENT OR REPRESENTATIVE:_____

DESCRPITION OF PERSONAL REPRESENTATIVES AUTHORITY:_____

AllCare Clinics
Family + Urgent Care

General Medical Records Release and
Authorization for Use or disclosure of Protected Health Information

Patient Name: _____Date of Birth: _____
Address: _____Phone:_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation for my health. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose/ release the full and complete protected medical information including the following *(*please check all applicable*):

[ ] All Records [ ] Laboratory/ Pathology Records [ ] X-ray/ Radiology Records
[ ] Billing Records [ ] Abstract/ Summary [ ] Pharmacy Records
[ ] Other (please describe specifically): _____

*__Note:__ *These records may contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/ alcohol abuse, or sexually transmitted diseases, and you are hereby authorizing disclosure of this information.*

These records are requested for the services provided on the following date(s):_____
Please send the records listed above (use additional sheets if necessary):

_____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Address

_____ _____
Phone Fax

The information may be used/ disclosed for each of the following purposes:
[ ] At my request (only the patient can check this box) [ ] Employment purposes
[ ] For my health care [ ] Other: _____

This authorization shall expire no later than: ___/___/___or upon the following event_____
(Whichever is sooner), and may not be valid for greater than one year from the date of signature for Texas medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of the protected health information and that there are no claims or orders pending, or in the effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print name and Relationship of Legally Authorized Representative Date

FINANCIAL POLICY

Allcare Family and Urgent Care Clinics, PA would like to welcome you to our office. The information below outlines how our practice operates. If you have any questions, please do not hesitate to ask. This is an agreement between AllCare Family and Urgent Care Clinics, PA, a Texas Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement, the words "**you**", "**your**" and "**yours**" mean the Patient/Debtor. The word "**account**" Means the account that has been established in your name to which charges are made and payments credited. The words "**we**", "**us**", and "**our**" refer to AllCare Family and Urgent Care Clinics, PA.

By executing this agreement, you are agreeing to pay for all the services received.

Monthly Statement: If you have a balance on your account, we you will receive a call from our office. It will show separately the previous balance any new charges to the account, the finance charges, if any, and payments or credits applied to your account during the month.

Payment options **if you have no insurance**.
- You need to pay cash or credit card on the day that treatment is rendered. **Please no checks**.

Payment options **if you have insurance**.
- You need to pay your deductible and any out of pocket portions at the time services are rendered by cash, or credit card.
- You need to pay all of treatment by cash, or credit card. Payment is due at time of service.

Payment: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issue, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of services.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, **you must pay that at the time of services**. It is the insurance company that makes the final determination of our eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and or pre-authorization may result in a lower payment from the insurance company. If your insurance fails to pay your claim then you are responsible for the balance owed to us. In the event that you do not have your insurance information with you and the insurance denies the claim then you are responsible for the balance due.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party in this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the portion of the charges not covered by insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and or pre-authorization may result in a lower payment from the insurance company.

Collection fees: A collection fee if up to $15.00 may be imposed on each account that is over thirty (**30**) days past due. We determine your account is past due by taking the balance owed thirty (**30**) days ago, then subtracting any payments or credits applied to the account during that time.

Required Payments: Any co-payments require by an insurance company **must be paid at the time of service.** Because this is an insurance requirement we cannot bill you for these fees. Please note, you can be penalized by your insurance company by not paying this amount.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than a 24 hour notice will be charged a $25.00 fee. This fee must be paid before a new appointment is scheduled. **Patients with three (3) missed appointments may be asked to transfer their records to another doctor.**

Forms: Various forms and letters are often lengthy and may take extra time to be filled out. Please allow up to 3 business days for forms or letters to be completed by our office. There will be a $35.00 charge for letters or forms needing more than a signature.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs. It is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

SIGNATURE PAGE FINANCIAL POLICY

Co-Signature: If this financial policy if signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement acknowledgment a copy of the AllCare Family and Urgent Care Clinics Financial Policy was given to you, you agree to all of the terms and conditions contained therein and the agreement will be in full force and effect.

Guarantor's Signature:_____Date:_____

Co-Signature:_____ Date:_____