Cedar Creek Clinic- Jonathan Edwards, MD

Lance Popham, FNP- Natalie Carter, FNP - Brandi Foster, FNP

Austin Ruppanner,FNP- Paul Stewart, FNP-Robert Orr, NP-Jennie Schneider, FNP

2418 W. Main Street, Gun Barrel City, TX 75156 Ph: (903) 713-2000 Fax: {903) 713- 2004

**New patient information**

Patient name: Date of birth: \_

Address: City: State: \_\_Zip: \_

Email: Cell#:.

Employer: Work#:.

Sex: Male or Female Social Security#: Drivers License#:. \_ Marital status: S M W D Spouse name: Cell#:. \_ Preferred pharmacy/city: How did you hear about us? \_ **PRIMARY INS:** lD# Group#

Policy holder name: Policy holder date of birth: \_ Social Security#: Relationship to patient: \_ **SECONDARY INS:** ID #: Group# \_

Policy holder name: Policy holder date of birth: \_ Social Security#: Relationship to patient: \_ **IF PATIENT IS A MINOR**

Responsible party: Relationship to patient: \_

Address: City: State: Zip:

Home phone#: Work phone#: Cell phone#: \_

I **hereby certify that** all **of the above information is** true **and correct to the best of my knowledge.** I **will notify this office of any changes that occur.** I **duly authorize direct payment to Cedar Creek Clinic for all services provided.** I **authorize the use of this form, or copy of this form, for all collection and insurance purposes.**

X

Signature of Patient/ Parent/ Guardian Date

PRIVACY INFORMATION

## Do we have permission to share your medical information with anyone? If yes, please list below.

Name:, Relationship:, \_ Name: Relationship:

## Please check if we have permission to share medical information on the following:

leave message on voicemail/machine (.\_

home

cell

work)

**EMERGENCY CONTACT**

## Please list who we would need to contact in the event of an emergency.

**We MUST have name, relationship to patient, and phone number.**

Name: Relationship: Phone: \_ Name: Relationship: Phone: \_ Name: Relationship: Phone: \_

Notice of Privacy Practices

## Acknowledgement of Review

Date: \_

Ihave reviewed Cedar Creek Clinic'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 notice if requested.

# X

Patient Name (Printed) Patient Signature

If completed by a patient's representative, please print and sign your name in the space below.

# X

Representative (Printed) Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

* Individual refused to sign
* Communication barriers prohibited obtaining the acknowledgment
* An emergency prevented us from obtaining acknowledgment
* Other ( please specify ):

X

Employee Signature

Date

Cedar Creek Clinic Office Payment Policy

**Given the constant changes to insurance company payment policies, the following in-office policies have been established to help us continue to provide the patient with the best quality of medical care. These policies are not meant to offend or insult anyone, but only to serve as a guideline for greater understanding in all aspects of patient care.** If **you would like to discuss the office fee schedule, or these office policies, please ask to speak to the Office Manager.**

**PAYMENT IS DUE AT THE TIME OF SERVICE.** This includes Co-pays, Deductibles, percentages

due, and non-covered charges. Other arrangements will be considered only when requested **PRIOR** to services being rendered.

1. Co-pay must be paid at the time of visit
2. For the patient's convenience, the office accepts cash, checks, VISA, MasterCard & Discover.
3. The patient is responsible for all NON-COVERED SERVICE CHARGES.
4. A $30.00 processing fee will be charged for all returned checks.

**ANY CHANGES to your DEMOGRAPHICS or INSURANCE** must be brought to our attention,

**BEFORE** the visit. Failure to do so may result in the patient being **responsible** in **FULL for**

**ANY** & **ALL charges** for services rendered. The **CORRECT** information is **CRITICAL** especially for

proper billing of laboratory test that may be required and ordered. If this information is incorrect or not current, the patient will be responsible for the bill in its entirety.

**Medicare cards MUST be Valid and UP-TO-DATE. We DO NOT accept any new MEDICAID. HMO, PPO, POS or other Health Plan ID cards must be current, have Dr. Edward's name and correct office phone number (if required by the plan).**

If you have medical insurance, as a courtesy to you we will try to speed up the processing of your claim by electronically submitting to your insurance company. However, your insurance is a contract between you and your insurance company. Our office **CANNOT** guarantee that your carrier will pay your claim. If your claim is denied by your carrier, the obligation for payment is the responsibility of the patient. Our office will not enter into a dispute with the insurance carrier over the claim. We will however, be happy to assist wherever possible.

All outstanding bills must be settled prior to receiving future care, unless **PRIOR** arrangements have been made.

**Print Name**

**Signature X\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

## Cedar Creek Clinic

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2418 West Main Street, Gun Barrel City, TX, 75156 Ph: (903) 713- 2000 Fax: (903) 713-2004

**Patient Personal Medical History**

|  |  |  |
| --- | --- | --- |
| Patient Name | Date of Birth | Social Security Number |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Surgeries | Phy:sicians |  Current Medications & Dosage | Shots |
|  |  | 1. | Tetanus: |
|  |  | 2. | Pneumonia: |
|  |  | 3. | Shingles: |
| Routine: | Health: | 4. | **ALLERGIES** |
| Pap Smear: | Physical: | 5. | 1. |
| Mammogram: | Colonoscopy: | 6. | 2. |
| Lab: | EKG: | 7. | 3. |

**Check all that apply**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Personal Medical Histoty |  | PersonalMedical Historv |  |  | Personal |  | Famil Histo!Y |
| Mental Historv | {Immediate} |
|  | Seasonal Allergies |  | Congestive Heart Failure |  | Suicidal Ideas |  | Heart Disease |
|  | STD |  | Diabetes |  | Insomnia |  | Diabetes |
|  | Alcoholism |  | Cancer |  | Victim of Abuse |  | Cancer |
|  | Drug dependence |  | Asthma |  | Smoke \_ppd |  | COPD/Emphysema |
|  | Black Stools |  | COPD |  | Alcohol \_dpd |  | Ulcers |
|  | Skin Lesions |  | Elevated Cholesterol |  | Drug Use |  | High Blood Pressure |
|  | Shortness of Breath |  | Emphysema |  | Anxiety |  | Depression |
|  | Hepatitis **A B** C |  | Stroke |  | Depression |  | Stroke |
|  | Pneumonia |  | Headaches |  | Rapid Ideas |  | Headaches |
|  | Reflux/ Ulcers |  | Arthritis |  | Concentration |  | Arthritis |
|  | Leg Swelling |  | Back Pain |  | Irritability |  | Thyroid Problems |
|  | Thyroid Disease |  | Fatigue |  | Sleep Problems |  | Elevated Lipids |
|  | HIV/ **Aids** |  | Seizures |  |  |  | Seizures |
|  | High Blood Pressure |  | Heart Attack |  |  |  |  |

Nurse/ Medical Assistant Signature: \_ Date: