|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **PATIENT INFORMATION** | | | | | | | | |
| Last Name | First Name MI | | | | | | Previous Name: | |
| Mailing address: | | | | | | | | |
| City/State/Zip | | | | | | | | |
| Home Phone Number: | Cell: | | | | | | | Work: |
| Preferred Method of contact: Text\_\_ Voice \_\_ | | | | | | | | Voice: on Cell\_\_ Home\_\_ Work \_\_ |
| Date of Birth: | | Sex: Male\_\_ Female\_\_\_ | | | | | | Previous PCP: |
| Marital Status: | | Social security number: | | | | | | Emergency contact name: |
| Employer Name: | | Relationship to Patient: | | | | | | Emergency contact number: |
|  | **RESPONSIBLE PARTY:** If patient is a minor(under 18) Parent or Guardian will be listed as Guarantor | | | | | | | | |
| Last Name: | | | First Name | | | | | |
| Date of Birth: | Social security: | | | | | Phone: | | |
| Address: | | | | | | | | |
| City/State/Zip: | | | Relationship to Patient: | | | | | |
| **ADDITIONAL INFORMATION:** | | | | | | | | |
| Email: | | | | | Can we leave message regarding tests and medical care? Yes\_\_\_ No\_\_\_ | | | |
| Race/ Ethnicity: | | | | | Preferred Language: | | | |
| Preferred Pharmacy Name & Location: | | | | | | | | |
|  | **INSURANCE INFORMATION:** | | | | | | | | |
| **Primary Insurance:** | | | | **Secondary Insurance:** | | | | |
| Ins Co Name: | | | | Ins Co Name: | | | | |
| Policy Holder name: | | | | Policy Holder name: | | | | |
| Policy holder Date of birth: | | | | Policy holder Date of birth: | | | | |
| Patient relationship to policy Holder: | | | | Patient relationship to policy Holder: | | | | |
| I have read the Patient Privacy Policy and office procedures and payment policy. I am eligible for the insurance indicated on the form and I understand that the payment is my responsibility regardless of insurance coverage. I hereby assign Crescent Clinic all the money to which I am entitled to, related to medical expenses related to services provided from time to time by Crescent Clinic, but not to exceed my indebtedness to Crescent Clinic. I authorize CC to release any medical information to my insurance carrier or third party to facilitate processing my insurance claims. Failure to Pay within 90 days of notification of the amount due will result in submission to an outside collection agency. A $35 fee will be charged for any returned checks due to insufficient funds. I choose to receive CC emails or text as stated above including but not limited to appointment, treatment and payments. I understand that these communications may not be secure and that there is a risk of being read by a third party.  MEDICARE BENEFICIARY: I request the payment of authorized Medicare benefits be made to Crescent Clinic. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable to related services. | | | | | | | | | |

I authorize the release of any medical information necessary to process medical claims filed on my behalf. I also request payment of government benefits and/or insurance medical benefits to the undersigned physician for the services described.

I have received a copy of Crescent Clinic Privacy Policy Notice, Prescription policy, Clinic Policy, Initials: \_\_\_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Adult Patient History

Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Annual Physical Exam: \_\_\_\_\_\_\_\_\_\_\_ Well Woman Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Exam: \_\_\_\_\_\_\_\_\_\_ EKG: \_\_\_\_\_\_\_\_\_\_\_\_\_

List all chronic medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List all medication dosages and frequency taken (including vitamins, minerals, and supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List all allergies / drug sensitivities and type of reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all prior surgeries and date of surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Problems With Depression: \_\_\_\_\_\_\_ Sleep: \_\_\_\_\_\_\_\_\_ Weight Gain / loss: \_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Colonoscopy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_ Last PAP\_\_\_\_\_\_\_\_\_\_\_ Last Bone density\_\_\_\_\_\_\_\_\_\_\_

Last Eye exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Other imaging: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunization History: COVID 19 \_\_\_\_\_\_\_\_\_\_\_\_\_\_FLU \_\_\_\_\_\_\_\_\_ Pneumonia \_\_\_\_\_\_\_\_Hepatitis B \_\_\_\_\_\_\_\_Td \_\_\_\_\_\_\_

Cigarette Smoking: \_\_\_\_\_\_How many Cigs/Day: \_\_\_\_\_\_\_\_ How many years: \_\_\_\_\_\_\_\_\_\_\_ Vaping: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol (Type and How Much, How Often): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recreational drug Use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Use: \_\_\_\_\_\_\_\_\_\_\_ Do You exercise (Type and how often): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recent Falls: \_\_\_\_\_\_\_\_

Any history of sexually transmitted disease? YES\_\_\_NO\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it treated? YES\_\_\_ NO \_\_\_

Family History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Information**

Preferred Retail Pharmacy

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Mail Order Pharmacy

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quantity you prefer to receive your prescriptions. \_\_\_\_ 30-day supply \_\_\_\_ 90-day supply Other: \_\_\_\_\_

Patient Check Off List: (Please initial next to the documents listed once you have read and reviewed them.)

\_\_\_\_\_ Patient Bill of rights

\_\_\_\_\_ Consent to Use and Disclosure of Health Information

\_\_\_\_\_ Patient Financial Responsibility

\_\_\_\_\_ Patient Notice of Privacy Practices

\_\_\_\_\_ Prescription Medication Policy

I have read and reviewed all documents listed above via the website: Crecentclinic.US or via hard copy provided by the office. I understand that by signing below it is my responsibility to follow all policies and requests in the documents listed above. If I have any questions or concerns regarding these policies/documents, I am aware that I may contact the office at 832-437-2427.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date

**Patient Bill of Rights**

All patients will be fully informed of their rights.

The patient has the right to appropriate, considerate, and respectful care.

The patient has the right to receive information necessary to give informed consent prior to the start of any procedure.

The patient has the right to treatment with respect, privacy, and dignity.

The patient has the right to reasonable continuity of care.

The patient has the right to be given reasonable notice of anticipated termination of services or of plans to transfer to another provider.

• The patient has the right to discuss problems with the physician without fear of discrimination.

• The patient has the right to be fully informed of the practice’s policies and procedures.

The patient and the public have the right to honest, accurate, forthright information regarding the health services provided.

**Consent to Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations**

I understand that as part of my healthcare, Crescent Clinic originates and maintains health records describing my health history, symptoms, examination findings, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

• A basis for planning my care and treatment.

• A means of communication among the health professionals who contribute to my care.

• A source of information for applying my diagnoses and surgical information to my bill.

• A means by which a third‐party payer can verify that the services billed were provided.

• A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revisions to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my

health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Crescent Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**Patient Financial Responsibility Statement**

Payment of your bill is considered part of your treatment. If you have medical insurance, we stand ready to assist you in receiving your maximum allowable benefits. To do this, we need your help to understand this statement of our financial policy. Note: Full payment is due at the time of service.

Insurance Coverage: Please understand that as a health care provider and healthcare facility, our relationship is primarily with you and not your insurance company. As a courtesy and convenience to you, we will file insurance claims for all our patients. We cannot bill your insurance company unless you give us current and accurate insurance information.

Copayments and deductibles for all insurance plans must be paid at the time of service. Failure to pay copayments will be reported to your insurance plan and to your employer. Copayments are a condition of your insurance coverage, and you may be subject to termination of your insurance benefits if you do not pay them.

Method of Payment: Cash, check, Mastercard, Visa, Discover and American Express payments are accepted.

Patients without Insurance: Occasionally, our patients may find themselves without health insurance coverage. Our policy states that 100% of all anticipated charges must be paid at the time of service.

Non-Sufficient Fund

Checks written to Crescent Clinic will have a $25.00 fee assessed to your account.

A letter will be sent to you requesting payment for services rendered. If no explanation or payment is received within 14 days, the account will be turned over to an outside collection agency.

Subsequent services will require cash payment in advance until the account is paid for in full.

**Patient Appointment Responsibility:** When you do not keep your agreed upon appointment, three people are affected. Firstly, you do not receive the needed treatment prescribed by your physician. Secondly, another patient could have benefitted by utilizing your appointment time. Finally, the physician now has a gap in the schedule due to time reserved for you. Our policy requires that an appointment be cancelled 24 hours in advance. If this is not done, there could be a $25.00 charge that you will be responsible for. This charge will not be covered by your insurance plan.

**Pre-Certification:**

Pre‐Certification (prior approval) may be required by your insurance plan before certain procedures or diagnostic testing. Please allow 48‐72 hours for this process to be complete. Please make sure that pre‐certification has been given before proceeding with any procedure or diagnostic testing.

**Prescription Medication Policy**

Crescent Clinic handles a large amount of prescription refill requests in the form of calls from patients, faxes from patients and pharmacies, and electronic requests from pharmacies. To continue providing the highest quality medical care and ensure your safety, we have implemented the following prescription policy.

Prior to your scheduled office visit, please look over all your medications, inhalers, diabetes supplies, etc. to determine if you need to request refills during your visit with the physician. All patients should bring their medications and supplements to the office visit for review, so we can keep accurate record of all medications prescribed by all medical providers involved in your care.

All chronic medications will require regular follow-up visits at our office. Your physician will determine the appropriate interval between visits. Please ensure that you have enough medication to last until your next scheduled visit. If you are overdue for your visit, your provider may provide enough medication to last until your scheduled appointment.

Medications for acute problems (cough, fever, etc.) will require an office visit to ensure that a correct diagnosis is made and that an appropriate medication is prescribed.

There are several methods on how to request a refill on your prescribed medication. The preferred method is to ask your physician during your scheduled office visit. If you need a refill between office visits and it is non-urgent, please call your pharmacy to have them send us a refill request. If the refill request is urgent, call our office directly to speak with our office staff. Please allow to the end of the business day for your refill request to be addressed by the physician.

We can send most prescriptions electronically or via fax to local pharmacies. We can call local pharmacies directly with your prescription information. We can provide written prescriptions for you to pick up at our office.

We can refill medications through mail order services. We prefer that you pick up a written prescription at our office so that you can check that the proper medication, dosage, and quantity were prescribed. Although rare, errors do happen, and you must be aware that mail-order pharmacies will not accept returns of incorrect medications and will not issue refunds. If you prefer, we can send medications either electronically or via fax to the mail order service; however, we will not be responsible for any refunds due to errors.

Certain controlled medications such as some pain medications, anxiety medications, and medications for ADHD must be sent directly to the pharmacy as electronic prescription without refills.

If you are changing pharmacies, please call the NEW pharmacy and request that your prescriptions be transferred from your OLD pharmacy. If they will not transfer, call our office to request that new prescriptions be sent to your new pharmacy.

If you are going out of town for an extended period and will need refills during your trip, please have the pharmacy at your destination contact your local pharmacy to transfer your prescriptions. When you return, have your local pharmacy contact your destination pharmacy to reverse the process.

Medications are prescribed for your use only and are not meant to be shared with others.

Refills are not provided after business hours or on holidays.