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:

First _____ Last _____ Middle _____

Previous Name or Maiden Name _____

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

Email Address_____

Address: Street Number _____ Street Name _____

City _____ State _____ Zip _____

Race:

- ☐ White
- ☐ Hispanic
- ☐ Asian
- ☐ Black / African american
- ☐ Other

Insurance Carrier Name: _____ Member ID: _____

Do you have secondary insurance? ❒ Yes ❒ No

SecondaryInsuranceName_____MemberID:_____

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 #** (_____)_____
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**
Maternal or Paternal (Please circle one)

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

Family History For (If known) for Grandfather (Please check) Deceased ❒ **Yes** ❒ **No**
Maternal or Paternal (Please circle one)

❒ 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

Have you recently been hospitalized? ❒ 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.)

*** Last Annual Physical: _____

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? _____

*******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 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.

Indemnification: I agree to hold harmless, and indemnify TBMC, its providers, and its staff, from and against all claims, demands, actions, suits, damages, liabilities, losses, settlements, judgments, costs, and expenses, including but not limited to reasonable attorneys' fees and costs (collectively, "Claims"), actually or allegedly, directly or indirectly, arising out of or related to (1) any medical complication related or unrelated to the health condition of concern; (2) any breach or violation of any covenant or other obligation or duty of Company under this Agreement or under applicable law; (3) any third party Claims which arise out of, relate to or result from any act or omission of Company; and (4) [other enumerated categories of claims and losses], in each case whether or not caused in whole or in part by the negligence of TBMC, or any other Indemnified Party, and whether or not the relevant Claim has merit.

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 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.

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

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. **A copy will be provided to you upon request.**

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, **payment IN FULL is expected at each visit AND IN ADVANCE.** If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles **must be paid at the time of service**. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. **You must pay for these services in full at the time of visit.**
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility

to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will NOT be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Initial _____

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 a 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.

_____ _____

Signature of Patient **Date**

THE BELOVED MEDICINE

Scheduled appointment times are reserved especially for you. If you fail to notify the clinic about any cancellation within 48 business-hour of your scheduled appointment time, you will be subject to a "No Show/Same-dayCancellation/Same-day reschedule" fee of $75.00. 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