OAKWOOD
FAMILY MEDICINE

TINA J. PHILIP, DO
511 OAKWOOD BLVD, SUITE 202 · ROUND ROCK, TX 78681
P 512.388.0511 · F 512.388.0510
EMAIL: INFO@OAKWOODFM.COM · WWW.OAKWOODFM.COM

NEW PATIENT INFORMATION

Last Name_____ **First Name**_____ **MI**_____

Birth Date_____/_____/_____ **SSN**_____ **Driver's License/State** _____

Mailing Address _____
Address Apt# City State Zip

Employer _____

Please list ALL available contact methods and indicate which is your preferred method
(MUST include one phone number and email)
Home Phone_____ ☐ Preferred
Cell Phone_____ ☐ Preferred
Work Phone_____ ☐ Preferred
E-Mail_____ ☐ Preferred

What Pharmacy Do You Use?_____
Name Street Phone

Relationship Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Sex on Birth Certificate ☐ Male ☐ Female

Sexual Orientation ☐ Straight/heterosexual ☐ Lesbian/Gay ☐ Bisexual ☐ Don't know ☐ Other _____ ☐ Prefer not to answer

Gender Identity ☐ Male ☐ Female ☐ Transgender man/FTM ☐ Transgender woman/MTF ☐ Other_____ ☐ Prefer not to answer

Race ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Native Hawaiian ☐ Other
Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other _____
Preferred Language ☐ English ☐ Spanish ☐ Other _____

EMERGENCY CONTACT

1ST Name_____ Phone_____ Relationship_____

2nd Name_____ Phone_____ Relationship_____

HOW DID YOU FIND US?

Search Engine Facebook/Instagram Family/Friend _____ HMO/PPO Directory

Employee_____ Hospital _____ Current Patient (Name) _____

Other Physician (Name) _____

CONSENT FOR TREATMENT: *I hereby consent to necessary examination procedures and/or treatment by my physician, her assistants, designees as is necessary in her judgment.*

Date_____ **Signature** (patient/guardian)_____ **Relationship**_____

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INSURANCE

Do you have Insurance? ☐ Yes ☐ No *If yes, please complete section below, if no please skip to Pharmacy info

Guarantor/Employee's Name_____ Employer_____

Sex_____ Birth Date_____/_____/_____ SSN_____ Pt's Relationship to Insured_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Insurance Co Name_____ Phone _____

Subscriber/Member ID#_____ Group#_____

Do you have secondary insurance? ☐ Yes ☐ No *If yes, please complete section below, if not skip to Pharmacy info

Guarantor/Employee's Name_____ Employer_____

Sex_____ Birth Date_____/_____/_____ SSN_____ Pt's Relationship to Insured_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Insurance Co Name_____ Phone _____

Subscriber/Member ID#_____ Group#_____

FINANCIAL POLICY

Oakwood Family Medicine is dedicated to providing the best possible care and service to you. The following financial policies have been adopted in order to follow the rules set by your health insurance and our office in order to be least disruptive to your appointments. If you have any questions regarding these policies, please contact us to discuss them further.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. Private pay patients will receive a prompt pay discount for payment in full at the time of service. For your convenience we accept Cash, VISA, MasterCard, American Express and Discover. While checks are not typically accepted, if payment is made by check and it is returned by our bank, a $50.00 returned check fee will be assessed to your account. Payment for the amount of the check and the $50.00 fee will be due before your next appointment can be scheduled.

YOUR INSURANCE

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the amount you are responsible for under the terms of your insurance contract (i.e. co-payment, co-insurance, deductible, non-covered services).

If you have insurance coverage with a plan which we do not accept (including auto insurance companies), the charges for your care and treatment are due by the patient/guardian at the time services are rendered. The prompt pay discount will apply if services are paid in full. If arrangements have been made and partial payment is given, the prompt pay discount will no longer apply and the full remaining balance will be due. We will provide you with a statement describing the services rendered which you may use to file a claim for reimbursement with your insurance company.

In the event that your health plan deems a service "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement or verbal notification from our office.

MINOR PATIENT

For all services rendered to minor patients, we will look to the adult accompanying the patient or the adult authorizing services to be rendered for the patient for payment.

MISSED APPOINTMENTS

Appointments must be canceled **at least 24 business hours** from the scheduled appointment time in order to avoid the late cancellation/no-show fee of $50.00. This fee is not paid by your insurance company and will be due before your next appointment can be scheduled. If you are running late, please notify us and we will do our best to fit you in on that same day, however please be aware that there are days with limited flexibility in the schedule. In the event that this is the case, please be prepared to reschedule

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your appointment for another day as well as pay the $50.00 missed appointment fee. The late cancellation fee may be waived on a case by case basis with proper notifications.

MEDICAL RECORDS
You may obtain a copy of your medical records upon request with a signed letter of release. Please allow 10 business days to receive your records. There will be a fee of $1.00 per page for the first 25 pages, then 25 cents per page thereafter. Payment is due upon receipt of records.

FORMS
Forms will be completed upon request. Please ensure all patient information is filled out prior to turning in the form to the office. Depending on length and information required, there may be a charge of $30 for completion of the form. If your form requires more information, you may be asked to make an appointment. Please allow 7-10 business days for completion of the form. Payment is charged upon receiving the completion request.

CREDIT CARD ON FILE
Oakwood Family Medicine is committed to efficiency and reducing waste. In order to simplify the billing process, avoid excessive statements and collections, we require that you provide a credit card on file with our office. Your card and payment information will be stored in secure software through a merchant service company for future transactions. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system. Credit cards on file will be used to pay account balances after insurance claims adjudication, forms/medical record copies, late cancellation/no show visits and virtual/telehealth visits. We will notify you about the payment and then will process the entire payment with your credit card on file. If we have not received full payment by the next billing cycle, we will charge up to $100.00 each billing period (every 28-30 days) until your balance is paid in full. If you have questions about your bill, please contact the office.

STATEMENTS & COLLECTIONS
Statements are sent out each month and are due upon receipt. Please note that you will be asked to pay your balance should you come in to the office for an appointment. **If after 60 days, your payment has not been received, your account will be subject to collections and a fee of 30% of the balance due will be added to your account.** Please contact our office to set up payment arrangements if necessary.

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak to our billing department if you have any questions, comments or concerns.

I have read, understand and agree with the financial policy of Oakwood Family Medicine. I understand that charges not covered by my insurance company as well as applicable co-payments, co-insurance and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Oakwood Family Medicine.

I authorize Oakwood Family Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

I understand and agree that Oakwood Family Medicine may amend these terms from time to time.

Date_____ **Signature** (patient/guardian)_____ **Relationship**_____

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GENERAL OFFICE INFORMATION

- Our hours are 8:00AM to 5:00PM, Monday through Thursday and 8:00AM to 12:00PM on Friday. After-hours calls are for ***TRUE*** emergencies only. Prescription refills will **NOT** be addressed after hours. No new medications will be filled over the phone/without a visit.

- You must notify us of any changes in your address, phone numbers or insurance coverage. Failure to report updated information in a timely manner could result in the denial of an insurance claim or delay the delivery of time sensitive information. Should a claim be denied due to lack of correct insurance information, charges will then become patient due.

- We encourage use of the patient portal; but it is **NOT** appropriate for urgent or time-sensitive matters. We cannot diagnose or render treatment by portal. An office appointment must be made for this due to Federal Privacy Laws.

- Prescriptions are sent electronically to the pharmacies for safety and security reasons.

- Please allow ***48 hours*** for refill requests. When refilling a prescription, we ask that you directly contact the pharmacy and they will fax a request directly to us. Doing so helps to reduce the possibility of errors being made when filling your prescriptions.

- If it is discovered that a patient is abusing a controlled substance (narcotics, etc), receiving multiple prescriptions from multiple physicians or using multiple pharmacies without notifying us, our doctor-patient relationship will be terminated. We will continue your care for a 30-day period allowed in order to transfer to another physician. In those 30 days, no controlled substances will be prescribed.

- We will not provide continuing care to patients who make requests that are illegal, unethical, or fraudulent.

- We do not overbook appointments in efforts to make wait time minimal. The time of your appointment is reserved specifically for you. If you need to cancel or reschedule your appointment, we ask that you notify us at least 24 hours prior to your appointment time. ***Failure to do so will result in a no-show/late cancellation charge of $50.00.*** Payment for these fees will be due by the patient/guardian prior to scheduling your next appointment.

- Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance. Likewise, if you feel that you had a negative experience in our office, please inform Dr. Philip as soon as possible.

I have read, understand and agree with the General Office Information of Oakwood Family Medicine.

Date_____ **Signature** (patient/guardian)_____ **Relationship**_____

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Notice of Privacy Practices

Our full Notice of Privacy Practices is located both online and in a binder at the Front Desk of our office. Once you have reviewed it please sign below. If you would like a copy to take home, please notify the Front Desk and we will get a copy for you.

I have reviewed Oakwood Family Medicine'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 documentation.

Date_____ **Signature** (patient/guardian)_____ **Relationship**_____

Release to Share Medical Information

Due to patient privacy, physician and staff at Oakwood Family Medicine are only allowed to discuss specifics of your medical care with people that you have designated.

I designate the following person(s) to be able to speak with the staff at Oakwood Family Medicine on my behalf about my medical condition or the status of my account. I release Oakwood Family Medicine and its staff from any claim of confidentiality with the release of this information.

Last Name_____ First Name_____ M.I____ Birth Date_____
Home Phone_____ Work Phone_____ Cell Phone_____

Last Name_____ First Name_____ M.I____ Birth Date_____
Home Phone_____ Work Phone_____ Cell Phone_____

Last Name_____ First Name_____ M.I____ Birth Date_____
Home Phone_____ Work Phone_____ Cell Phone_____

Date_____ **Signature** (patient/guardian)_____ **Relationship**_____

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Informed Consent to use Patient Portal

Oakwood Family Medicine offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physician. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the Web site uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should promptly go to the web site and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures as set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications.

Confidential email (please print clearly): _____

Patient Name: _____ **Date of Birth**: _____

Print name of Parent/Guardian requesting access: _____

Signature: _____ **Date**: _____

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TELEHEALTH VISIT CONSENT FORM

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting Oakwood Family Medicine at (512) 388-0511.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit or if telemedicine is not covered by my insurance carrier. If not covered, there will be a charge of $50.00
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that all financial policies of the office apply to telemedicine visits as well (late cancellation, no show,
8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date