ALLEGIANCE CARE

Shelly Wray, FNP-C
1901 Medi Park, Ste 6
Amarillo, Tx 79106

NEW PEDIATRIC PATIENT PACKET (FOSTER)

REGISTRATION INFORMATION	
Patient Name:	Gender: ____M_____ F
Date of Birth:	Marital Status: S M W D
Social Security:	
Race: White/African America/Native American/Alaskan/Filipino/Other:_____ Ethnicity: Hispanic/Not Hispanic	
Address:	
City: State:	Zip:
Is there a Durable Power of Attorney (POA) ___YES ___NO if yes please submit a copy	
How did you hear about us? ___TV ____ Radio ____ Billboard ____ Other: _____	

CONTACT INFORMATION	
Home Phone:	Cell Phone:
Email:	
Preferred Communication: Phone Text Email Portal	

EMERGANCY CONTACT INFORMATION	
Name:	Home Phone:
Address:	Cell Phone:
Relationship to Patient:	
Please give the name and phone number of a relative or friend not living with you whom we may contact in the event of a medical emergency.	
Primary Insurance Information	
Name:	Subscriber Name:
Phone:	DOB:
Policy Number:	

PREFERRED PHARMACY	
Name:	Address:
I acknowledge that Allegiance Care may use health information exchange systems to electronically transmit, receive and/or access my prescription history.	

OTHER PROVIDERS		
SPECIALIST	Name	Last Visit
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_		

Please bring to every appointment: Current Medication List, CPS Paperwork, any additional paperwork you may need.

Placement Paperwork and Medical Consenter paperwork required at each new placement regardless of establishment status.

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Patient Name: _____ Date of Birth: _____

ALLERGY □ NKDA	ALLERGIC REACTION

Please list all medications you are currently taking. Include over the counter medications, herbs, and vitamins. (If you have a list please submit with your form)

HOSPITALIZATIONS		
TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

MEDICATION	DOSAGE	HOW OFTEN	MEDICATION	DOSAGE	HOW OFTEN

PERSONAL MEDICAL HISTORY			
DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Anemia			
Asthma			
Cancer *(type:_____)*			
Constipation			
Convulsions/Eplilepsy			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes			
Diarrhea			
Ear Infections			
Headaches			
Hearing Problems			
Heart Disease			
Vision Problems			
Other:			

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FAMILY MEDICAL HISTORY	□ NO SIGNIFICANT FAMILY HISTORY IS KNOWN																	
CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicid	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:	Other:	Other:
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:_____																		

SOCIAL HISTORY			
TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	*Past:* Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: □ Pipe □ Cigar □ Snuff □ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	□ Beer □ Wine □ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			
EMOTIONAL	In the last two weeks, have more than half the days feeling down, depressed or blue? Y N	Have you ever, or are you currently having suicidal thoughts? Y N Have you ever or are you currently having homicidal thoughts? Y N	
SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*		
Sexual partner(s) is/are/have been: □ Male □ Female			
Birth control method: □ None □ Condom □ Pill/Ring/Patch/Inj/IUD □ Vasectomy			
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*		
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____		
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?		
DIET	How would you rate your diet? □ Good □ Fair □ Poor	Would you like advice on your diet? Y N	
SCHOOL HISTORY	Did/Does the patient attend school/preschool? □ Yes □ No	Current grade in school?	
Do you have concerns with how the patient is doing in school? □ Yes □ No			
Any concerns about relationships with teachers or other students? □ Yes □ No			
If more than 4 years old: does your child have a best friend? □ Yes □ No			
Does your child play any sports? □ Yes □No	How many times a week?	How long (minutes)?	

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ALLEGIANCE CARE POLICIES:

Please initial next to each policy

_____ **Appointment Policies:**

No-Show: Failure to show to your scheduled appointments will result in a $30 fee and will be added to your account and collected prior to your next appointment. 3 or more no-show appointments may result in termination of care from our office, it will be based on case-by-case review.

Late Appointments: Please understand that we reserve the right to reschedule your appointment to a future date if you are more than 15 minutes late for your appointment. If you are unable to arrive at your appointment on time, we appreciate your courtesy of letting us know as far in advance as possible.

_____ **Medication Policies:**

Refills: To eliminate potential medication lapse, our office will not refill chronic medications unless a follow-up appointment is on the schedule. We require a 48-hour notice for medication refills, please inform the receptionist of the name and dosage of each medication you need. Medications will be sent to the pharmacy on file and will not be refilled on holidays, weekends or during non-business hours.

Antibiotics: Antibiotics will not be called in for patients if they have not been seen in the clinic in the last 14 days. This policy will be reviewed on a case-by-case basis and is not a guarantee.

Controlled/Narcotic Medications: Controlled medications must have a controlled contract on file with Shelly Wray, FNP-C and cannot have another controlled contract with a different doctor unless approved.

_____ **Administrative Paperwork Policy:**

All administrative paperwork (Examples include but are not limited to: FMLA, Short Term Disability, Surgical Clearance, ect…) may take up to a week to complete and may be subject to a $25 fee prior to completing the paperwork. It is at providers discretion whether or not an appointment will need to be made in order to fill out the paperwork.

Medical Records:

Medical Record Requests must be submitted in writing. Personal, insurance, or Attorneys office fees will comply with the Texas Medical boards current rate of charge. Fee must be paid prior to medical request being initiated. Physician to Physician request will not incur a fee.

_____ **Financial Policy: All co-pays, additional fees, or cash payments are due before the time of service. We accept cash, credit, or check. Returned checks will result in a $30 fee, and checks will no longer be accepted.**

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. 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.

Primary Care Physician (PCP) Selection: Most insurance plans require a PCP selection, it is your responsibility to make sure Shelly Wray, FNP-C OR Allegiance Care is selected as your PCP. Failure to do so may result in non-payment by the insurance company, and the balance will transfer to the patient.
It is our preference that a patient only has one PCP, however, if you would like to continue to see us for sudden illness's or when necessary, we will gladly see you, but we will not fill chronic medications, administer vaccinations, preform referrals, administrative paperwork, or clearances.

Chronic Care Management (CCM): Our clinic participates in CCM, under the Medicare Physician Fee Schedule (PFS), Medicare and certain commercial insurance companies now pay for non-face-to-face care management services that are provided to beneficiaries with two or more chronic conditions. If you qualify you will be notified by our CCM Coordinator, and services will be billed to your insurance.

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.

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Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. In order to submit these claims, we are required to have your signature on file for a HCFA 1500. By signing this policy, your signature will act as your "signature on file" for claims submission. 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.

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. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

_____ Car wrecks and Work-man's Compensation:

Allegiance care will not bill for car wrecks or work-man's compensation under any circumstance. If you wish to continue to see us, payment for the visit will be required up front and you will receive an itemized statement to give to the responsible party.

_____ General Consent for Treatment:

I hereby voluntarily consent to all healthcare services ordered/provided by Allegiance Care. The health care service may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical treatment; routine laboratory procedures and test; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I consent to examinations, treatments, procedures, and blood test ordered by the healthcare provider, which may include blood test for diseases such as hepatitis and HIV AIDS.

I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect until I withdraw my consent, which may be done in writing at any time or until the center changes its services and ask me to complete a new consent form.

I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that students may be involved in treatment, and I consent thereto.
4. I understand that I can ask for the student(s) to not be present in the room at any time during any visit.
5. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
6. I hereby voluntarily give my consent to treatment at Allegiance Care.

_____ HIPAA Acknowledgement of Privacy Practices

I have been notified of Allegiance Care's "Notice of Client Privacy Rights." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act, and a copy is available upon request.

_____ Notice of prior paperwork and policies –

Any and all prior paperwork under The Medical Home Team, or C&T Med LLC, including pain contracts will continue to be in effect until notified by Shelly Wray, FNP-C or Allegiance Care LLC.

_____ Date: _____

Patient/Authorized Representative

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient: _____ Date of Birth: _____

Records Dated From: _____ To: _____

By signing this form, I authorize the release of confidential health information TO:

ALLEGIANCE CARE
ATTN MEDICAL RECORDS
1901 MEDI PARK DR, STE 6
AMARILLO, TX 79106

SHELLY WRAY, FNP-C
PHONE: (806) 576-1095
FAX: (806) 576-0415

INFORMATION TO BE RELEASED:

□ History & Physical	□ Consultation Report	□ Emergency Room Records
□ Operative Reports	□ Discharge Summary	□ Face Sheet
□ Referral Record(s)	□ All Medical Records	□ Other: _____

Please specify destination to which records are to be released FROM:

Name of Location:	
Name of Physician:	
Address:	
Phone #:	
Fax #:	

- I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.
- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
- The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

_____ Date: _____
Patient/Authorized Representative Signature

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_____ Date: _____

Patient/Authorized Representative Signature