Franklin Clinic

Demographics

Last Name: _____ First Name: _____Middle: _____

DOB: _____ Driver's License # _____ Social Security # _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone # Home: _____Cell: _____Work: _____

Sex: Male Female Marital Status: Single Married

Email: _____ Ethnicity/Race: _____

Your email will allow you to receive appointment/medical reminders and your medical records via patient portal.

Occupation: _____ Employer Name: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy

Preferred Pharmacy: _____ Address: _____

Mail Order Pharmacy: _____ Phone: _____

Are you self-pay? YES NO

Primary Insurance (Image of Card Required)

Insurance company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance (Image of Card Required)

Insurance company: _____

Address: _____ Phone: _____

Policy Number: _____ Group Number: _____

Policy Holder Name: _____ DOB: _____ Relationship to Patient: _____

New Patient acceptance is pending initial consultation with medical provider. This can be an in office or virtual visit. Office visit fees will apply.

I would like _____ In office or _____ Virtual consultation.

Franklin Clinic

Insurance: _____ Today's Date: _____
Name: _____ Date of Birth: _____

**************If you need more space please use back of form**************

List all Medications you take including supplements	Dosage or strength	How often do you take this?	What is this prescribed for?

**************If you need more space please use back of form**************

Medication Allergies?		
Do you use tobacco products?		**Do you consume alcohol regularly?**
Circle or list any condition you have been diagnosed with:	Chronic Pain	Thyroid Disorder
	Gastrointestinal Disease	COPD/Lung Disease
Diabetes	Heart Disease	Vascular Disease
Autoimmune Disease	Skin Disease	Hypertension
Depression	Anxiety / PTSD	Seizures/Neurological Disease
Cancer:	Other:	Other:
Other Mental Health Condition:		
List all surgeries you have had:		
Have you been hospitalized in the last 12 months?		
*If yes, where & what for?		
Most recent primary care provider?		
Reason for change?		
List any other doctors you are seeing and why:		

How did you hear about us? _____

Franklin Clinic Policies

We would like to thank you for choosing Franklin Clinic as your healthcare provider. We are committed to providing you with the best possible medical care. Understand that payment for your care is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many insurance companies and government agencies including Medicare. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance requires a referral, it is your responsibility to schedule an appointment with your PCP to obtain a referral. Please bring your insurance card(s) with you at the time of your appointment.

If you are insured by a plan, we do business with, but don't have an insurance card with you, payment in full for each service is required until we can verify your coverage.

Co-Payments and Deductible:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay your co-payment your appointment will be rescheduled.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. These amounts are due at the time of service. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Coverage Changes:

If your insurance changes, please notify us at least 48 hours before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any charges incurred by you because of failure to provide any necessary information will be your responsibility.

For our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit.

Late Arrivals:

A patient who arrives more than 5 minutes after his/her check in time is considered a late arrival. A late arrival may be seen under Urgent Care and is subjected to the Urgent Care Fees or rescheduled for a later time.

Appointment Rescheduling and No-Shows:

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient may be charged $50.00, as set by the practice. A patient who fails to present three times for scheduled appointments is considered a chronic no-show and may be dismissed from the practice. Any annual wellness appointment rescheduled less than one week in advance will be charged a $25 rescheduling fee. Any patient who fails to show for their annual wellness appointment will be charged a no-show fee of $50.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full prior to any new services. A delinquent account is defined as a patient balance in excess of 90 days when patient has been adequately notified and has not made any payments or sought assistance via financial hardship during this time. Failure to uphold your financial agreement may prevent patient from receiving future services. I agree to pay any costs incurred by Franklin Clinic in collecting any amount due including, without limitations collection agency fees and attorney’s fees.

Patient Communication System:

Patients are enrolled in our communication system for appointment/medication reminders and health records access. These reminders are sent via phone call, text message and email/patient portal. If you choose to opt out of one of these please notify the office promptly.

By signing below, I acknowledge and agree to the terms and responsibilities laid out in this document.

Patient Signature_____ Date: _____

Guarantor Signature_____Date: _____

Annual Wellness Visit

In order to provide the best patient care that you deserve, the Franklin Clinic has adopted the guidelines for the Annual Wellness Visit (AWV), a standard that has been extensively researched and approved by the Center for Medicare Services (CMS). Most insurance plans have assumed this standard as it ensures patients have the most current medical care and clinicians have the information they need to partner with their patients. We ask that all patients schedule their Annual Wellness Visit with follow up visit. You may have co-payment, coinsurance and/or deductible amounts required by your insurance carrier. A rescheduling fee of $25 will be assessed for any appointment rescheduled less than one week in advance. A no-show fee of $50 will be assessed for any appointment not kept.
By signing Below, I acknowledge and agree…

Patient Signature_____ Date: _____

Accountable Care Organization and Blue Button

Your doctor or primary care provider is participating in Alliance ACO, our Medicare Accountable Care Organization (ACO). An ACO is a group of doctors, hospitals, and health care providers working together with Medicare and other insurance providers to give you high quality care, if you are Medicare beneficiary, we need your permission to access the Medicare Blue Button which is your health and claims data information on MYMEDICARE.GOV.

Patient Signature_____ Date: _____

Informed Consent for Franklin Clinic Telemedicine / Televisit Consultation

I consent to take part in a telemedicine consultation with The Franklin Clinic and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation. I understand the following: The purpose is to assess and treat my medical condition; telemedicine consult is done through a two-way video HIPAA compliant link-up. The Franklin Clinic and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others. I know there are potential risks with the use of this technology. These include but are not limited to: Interruption of the audio/video link, disconnection of the audio/video link, a picture that is not clear enough to meet the needs of the consultation, electronic tampering. If any of these risks occur, the procedure may need to be stopped. In order to participate in the telemedicine program, I agree to pre-pay for these visits at time of scheduling with the front desk. No appointment will be booked without payment. By signing this consent, I agree to the charges on my credit card or Care Credit. I understand these services are offered to self-pay/commercial insurance and Medicare. I, the undersigned patient, do hereby understand and state that I agree to the above consents and I am doing so of my own free will. I understand I can always opt for an in-person office visit. I certify that this form has been fully explained to me. I authorize The Franklin Clinic and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Patient Signature_____ Date: _____

Health Information Exchange

Franklin Clinic participates in Commonwell and Carequality health information exchange that facilitates electronic exchange of patient information with physicians, hospitals, labs, pharmacies and other providers. HIE will also connect to other HIEs to allow information to be available to other providers when patients travel outside of our region. Sharing patient information with other providers through HIE and EMR helps Franklin Clinic save patients' time and make better treatment decisions with a more complete patient record. It will allow them to avoid duplicate tests and procedures and gain immediate access in emergencies to critical information like allergies, diagnosis, medications and other important data. You may request an **Opt Out** form from Franklin Clinic staff and they will help you complete it. Franklin Clinic will not discriminate against you if you choose to sign an **Opt Out** Form.

Patient Signature_____ Date: _____

Authorization and Agreement for Treatment
HIPAA Acknowledgement and Consent:

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health information for its treatment, payment, healthcare operations, and other de-scribed and permitted uses and disclosures, I understand that I may contact the Privacy Officer on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and discloser of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of information. I hereby permit the practice and the physicians or other health professionals involved in the inpatient or out-patient care to release healthcare information for the purpose of treatment, payment, and healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or other purpose related to benefit payment. Healthcare information may also be released to my employer's designed when services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid claim, I authorize the release of healthcare information to the Social Security Administration or this intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psycho-logical and /or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insures and / or health care industry participants and their subcon-tractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposed; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic in-formation, chemical dependency conditions and/ or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient Signature_____ Date: _____

Guarantor Signature_____Date: _____

I _____, give permission for my protected health information to be disclosed for purpose of communicating results, findings and care decisions to the family members and others listed below:

Name _____Relationship _____ Contact Number _____

Name _____Relationship _____ Contact Number _____

Name _____Relationship _____ Contact Number _____

Name _____Relationship _____ Contact Number _____

Franklin Clinic Code of Conduct

Defines acceptable standards of behavior for patients, chaperones and caregivers. All patients, as a condition of their continued treatment by a provider, will abide by Franklin Clinic rules, regulations, policies, and all other lawful standards.

1. Patient will treat all staff members with respect with words, body language, or gestures.
2. Patient will refrain from any form of violence (verbal, sexual, or physical) to any person. This includes sexual, ethnic, or other types of harassment, whether verbal or physical in nature.
3. Patient will be honest and factual with all communication with Franklin Clinic staff
4. Patient will be considered non-compliant for repeated and/or deliberate violation of Franklin Clinic rules or policies.
5. Possession of illicit drugs or alcohol on the premises is not allowed.
6. Legal prescriptions and over the counter drugs may be brought on premises if used in their prescribed manner.
7. Our facility is smoke free, this includes vaping.
8. Weapons (including but not limited to firearms) are not allowed within our buildings, with exception provided to law enforcement personnel.
9. Attending sessions/appointments "under the influence" may be grounds for restriction of privileges, rights, and services, or termination/discharge.
10. Persons believed to be under the influence will be given the opportunity to call someone to pick them up, or transportation will be arranged by our staff. If they leave the facility driving a vehicle, law enforcement will be notified.

REPORTS OF DISRUPTIVE BEHAVIOR

If any individual working at Franklin Clinic reasonably believes that a patient is engaging in disruptive behavior or has broken our Code of Conduct protocol, he or she may discuss directly with the client/patient, document the incident, and advise their immediate supervisor as soon as possible.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

YOUR RESPONSIBILITIES

1. You are expected to provide complete and accurate information about your health and medical history, including present condition, appointments with other providers, past illness, hospital stays, medication updates, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
2. You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling the provider. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
3. You are expected to actively participate in you care management plan and to keep your providers and staff informed of the effectiveness of your treatment.
4. You are expected to sign a release of information when transferring care from another provider. This will allow us to obtain your medical record from them.

YOUR RIGHTS

1. You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
2. You have the right to apply for payment plans if you feel you cannot afford your healthcare. You will be responsible for bringing in your proof of income when requested. You may reapply at any time if your situations changes.
3. You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
4. You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
5. You have the right to be free from restraints and seclusion in any form that is not medically required. 6. You can expect full consideration of your privacy and confidentially in care discussions, exams, and treatments. You may ask for an escort during any part of your exam.
7. You have the right to communication that you can understand. We will provide sign language and foreign language interpreters as needed at no cost to you. Information given will be appropriate to your age, understanding, and language. If you have vision, speech, hearing, and/or other impairments, you will receive additional aids to ensure your care needs are met.
8. You have the right to make an advance directive and appoint someone to make health care decisions for you if you are unable. If you do not have an advance directive, we can provide you with information and help you complete one.
9. You have the right, upon your request, to transfer your care to another provider within the organization if other qualified providers are available.
10. You have the right to receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse the course of treatment, the medically significant risks involved in each, and the name of the person who will carry out the treatment or procedure.

Patient Signature: _____ Date:_____

723 Hill Country Dr, Suite C
Kerrville, TX 78028
P: 830.792.5800
F: 830.896.2625

Franklin Clinic

Patient Name_____ DOB_____ Soc. Sec. No. XXX-XX-_____ Phone: _____

Address_____City_____State_____Zip_____

Release information From:
Specify Provider/Organization Name and Facility Address

Organization Name: _____

Address: _____

Phone: _____

Fax: _____

Release information To:
Specify Provider/Organization Name and Facility Address

Organization Name: Franklin Clinic

Address: 723 Hill Country Dr. Suite C

Phone: 830-792-5800

Fax: 830-896-2625

Please release the past 2 years of the following information, indicated by an "X" unless otherwise specified:

- ☐ Office Visit Notes
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Immunization record
- ☐ Medication Record
- ☐ Dental
- ☐ Consultation Reports
- ☐ Outside Records
- ☐ From _____year To _____Year

Your initials are required to release the following information:

- ☐ HIV Medical Information _____
- ☐ Behavioral Health Records _____
- ☐ Substance Abuse Records _____
- ☐ Genetic information (including genetic test results _____

This information is necessary for the following purposes:

☐ Follow – Up Care ☐ Patient is requesting disclosure ☐ Disability Benefits ☐ Attorney ☐ Other Please explain:

_____

Please release my information via: ☐ Fax (Preferred) ☐Disc/Electronic ☐ Pick up paper copy

The patient or the patient's representative must read the following statements:
I, the undersigned, understand that I may revoke this consent at any time in writing by completing the revocation authorization form, except to the extent that action has been taken in reliance on it and that in any event this consent shall expires 12 months from when it is signed unless otherwise specified (Otherwise specified date_____). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, Franklin Clinic can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the Franklin Clinic return address listed above.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules.

I understand any of the above requested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
If form is not complete, we may be unable to fulfill this request.

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulations 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.

_____ _____ _____
Signature of Patient or Authorized Party **Date** **Relationship to Patient**

Witness_____ **Reason Patient is not signing** _____