Mark A. Cline, MD
Laura Briggs, ACNP-BC
Candace Carter, FNP-C
630 Hurst Street
Center, TX 75935
P(936)657-1944 F(936)591-9155

PATIENT INFORMATION

Name: ____ Date of Birth: ______________ Age: _______ Sex: M / F

Mailing Address: ____________________________________ City, State, Zip: _____________________________

Home Phone: __________________ Work Phone: __________________ Ext. ________ Cell: _________________

Marital Status: S M D W SS#: _______________________ Email: __________________________________

Employer: ____ Full / Part Time

Employer Address: ____________________________________ City, State, Zip: ____________________________

Race: (circle one) American Indian, Alaskan Native, Asian, African American, Native Hawaiian or other Pacific Island, White, Other

Ethnic Group: (circle one) Hispanic or Latino, Not Hispanic or Latino

POLICY HOLDER INFORMATION Relationship to Patient: ______________________

Name: ____________________________________ Date of Birth: ______________ Age: ___________ Sex: M / F

Mailing Address: _____________________________________ City, State, Zip: _____________________________

Home Phone: __________________ Work Phone: ___________________ Ext. ________ Cell: _________________

Marital Status: S M D W SS#: __________________________ Email: ________________________________

Employer: ____ Full / Part Time

Employer Address: _____________________________________ City, State, Zip: ____________________________

EMERGENCY CONTACT:

Name:_______________________________ Relationship:_________________________ Phone: _______________

Cell Phone:__________________ Work Phone:____________________

How did you hear about us? ____

SIGNATURE:____ **DATE:** _________________________

Initial **CONSENT TO TREATMENT**

__________I voluntarily consent to receive medical and healthcare services provided by Cline Family Medicine that they deem necessary in my diagnosis and treatment. I understand that such services may include diagnostic procedures, examinations, and treatment. The services will be provided by an Allied Health Professional supervised by Dr. Mark Cline. You may be seen by Dr. Cline by asking to be put on his Tuesday schedule.

ASSIGNMENT OF BENEFITS

__________I assign all insurance benefits for medical and healthcare services I am rendered by Cline Family Medicine and/or their staff to be made payable to Cline Family Medicine. I certify that I have provided complete information in regards to all insurance coverage I am currently involved.

FINANCIAL RESPONSIBILITY

_________I agree to pay all charges for medical and healthcare services not covered by, or which exceed the estimated amount to be paid by Medicare, Medicaid, commercial or other third-party payers and agree to make payment as requested by Cline Family Medicine.

HIPAA NOTICE OF PRIVACY PRACTICES

__________I acknowledge that I have been given access, upon my request, to a copy of Cline Family Medicine's Notice of Privacy Practices.

This consent/assignment/authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for any charges not paid by said insurance carrier(s).

_______________________________________ _______________________________

Patient/Legally Authorized Signature Date

____

Print Name/Relationship

Patient Authorization for Disclosure of Protected Health Information

I, _______________, hereby authorize Cline Family Medicine's medical staff to disclose or provide protected health information to myself, any of the individuals listed below, or the physician(s) listed on this form via phone, fax, mail, or e-mail addresses. I authorize Cline Family Medicine to disclose appointment information or financial obligations to individuals, phone numbers, or addresses listed on this form. I understand this authorization will remain in effect until I choose to submit in writing that I wish to have it revoked.

Designated Individual(s) **Relationship to Patient**

_______________________________________ _______________________________
_______________________________________ _______________________________
_______________________________________ _______________________________

_______________________________________ _______________________________

Patient Signature **Date**

No Show Policy

Cline Family Medicine strives to be available to our patients to provide quality healthcare. When a patient does not show up for their requested appointment without notifying us at least a day in advance, other patients are delayed in their care.

We feel that it is very important that each patient in our care be given the opportunity to be seen in a timely manner.

If a patient does not show up for their appointment, that patient will be subject to a **$25 charge** added to the patient's account for the scheduled appointment time. If no shows become a chronic problem, no appointments will be made for the patient and the patient will be seen as a walk-in only with longer wait times.

Please help Cline Family Medicine to provide all our patients with much needed healthcare by **contacting our office 24-hours before your appointment time** if you are not going to be able to attend.

"Hot" Checks

Any time a check is returned to Cline Family Medicine due to insufficient funds, there will be a **$35** charge added to the patients account to cover the bank fees incurred by the 'hot check'.

Late Fees

We understand that balances cannot always be paid off in one month. The office will work with you on payment arrangements. If no arrangement is made, late fees will apply and if no payments are made your account will be sent to a collection agency.

Refill Requests

Please notify the staff **48** business hours before a refill is needed.

Paperwork/Forms Requests

Please give the staff paperwork/forms 7 business days before the paperwork/forms are due. If an office visit is not required, there will be a fee for the paperwork depending on the length of time to complete.

Appointments with Dr. Cline

Patients have the option of seeing Dr. Cline instead of one of the mid-level providers. Please communicate your preference to the front office.

______________________________ ______________________________

Patient Signature Date

By signing, I have read and fully understand the above office policies.