Be Well Primary Care
Compassion. Care. Excellence.
Your health is our priority.

**Dr. Radhika Vayani**
3800 N Tarrant Parkway, #210
Fort Worth, TX 76244
682.593.6660

**DATE**:_____

## PATIENT INFORMATION

Patient Name: First_____MI_____Last_____SS# _____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

**Race**: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
**Ethnicity**: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Do you have any communication difficulties/ special needs? Hearing Loss Interpreter Required Reading Difficulty Sight Impaired Other? Yes No

If yes, please list: _____

Address:_____Apt #_____City_____St_____Zip _____

Phone: Home_____Cell_____Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence from Be Well Primary Care

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired Employer/School:_____

## FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address:_____Apt #_____City_____St_____Zip_____

Phone: Home_____Cell_____Work_____

Email Address _____

Employer: _____

## EMERGENCY NOTIFICATION

Name:_____Relationship to Patient: _____

Phone: Home_____Cell_____Work_____

Name:_____Relationship to Patient: _____

Phone: Home_____Cell_____Work_____

## REFERRAL SOURCE

□ Friend/Family Member □ Insurance Company □ Walk-in □ Face Book/Social Media □ Direct Mail □ Magazine □ Web Search □ Practice Website □ Event

□ Zoc Doc □ Another Physician/Provider _____ □ Other _____ □ Hospital / ED _____

## OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize Be Well Primary Care and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Be Well Primary Care of changes or update. I authorize Be Well Primary Care to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name_____Relationship_____Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

Name_____Relationship_____Phone_____

You may release the following information to the person named above: □ Appointments □ Billing Information □ Medical Care □ Leave Message

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the Internet. **Initials** _____

### Please provide a copy of all Insurance Cards and a Driver's License / Photo ID

You will be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

## INSURANCE INFORMATION

Medicare ID# _____

Do You Have Insurance Primary to Medicare? Yes No If Yes, Please List: _____

Medicare Supplement _____ ID#_____

Medicare Advantage Plan _____ ID#_____

Medicaid ID# _____

**Or**

**Commercial Insurance**

**Primary Insurance**_____ID_____Gp: _____

Policy Holder Name:_____Relationship (Circle One) Self Spouse Parent Other _____

SS#_____Policy Holder's DOB_____Employer_____

**Secondary Insurance**_____ID:_____Gp_____

Policy Holder Name:_____Relationship (Circle One) Self Spouse Parent Other _____

SS#_____Policy Holder's DOB_____Employer_____

## MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. **Initials** _____

Pharmacy Name_____Address or Cross Street_____

# PATIENT HEALTH INFORMATION

PERSONAL INFORMATION

Date_____/_____/_____Date of Last Physical Exam_____/_____/_____

Last Name_____First Name_____MI _____

Preferred Name_____DOB_____/_____/_____Age _____

DRUG ALLERGIES ☐ No Known Drug Allergies (NKDA)

| Name of Medication or Food Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

CURRENT PRESCRIPTION MEDICATIONS: ☐ None

| Name of Drug | Dose (mg/mcg) | # tablets/day | # times per day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

MEDICAL HISTORY

Have you or immediate family members ever had any of the following:

| Relationship To You | Status A- Alive D- Deceased | Date of Onset (If known) | Cancer (Specify) | Diabetes | COPD | Coronary Artery Disease | Heart Disease | High Cholesterol | High Blood | Pneumonia | Stroke | Thyroid Hyper/Hypo | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Self** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **Mother** | | | | | | | | | | | | | | | |
| **Father** | | | | | | | | | | | | | | | |
| **Brother** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **Sister** | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |

□ Adopted – not able to provide medical history

HOSPITALIZATIONS/SURGERIES

| | Description | Year | Name of Hospital |
|---|---|---|---|
| **Illness** | | | |
| | | | |
| | | | |
| **Surgery** | | | |
| | | | |
| | | | |
| **Other** | | | |

PERSONAL HABITS

| .5 | 1 | 1.5 | 2 | 2.5 | 3 |
|---|---|---|---|---|---|

| 2 | 5 | 10 | 15 | 20 | 25 | 30 |
|---|---|---|---|---|---|---|

ADDITIONAL PERSONAL INFORMATION

| **Procedure** (Please indicate date of most recent procedure.) | **Year** | **Immunizations** (Please indicate date of most recent injection.) | **Year** |
|---|---|---|---|
| **Bone Density** | | **Flu** | |
| **Colonoscopy** | | **Hepatitis A** | |
| **Mammogram** | | **Hepatitis B** | |
| **Pap Smear** | | **Pneumonia** | |
| **PSA or Prostate Exam** | | **TDaP (Tetanus)** | |
| **Eye Exam** | | **Zostavax (Shingles)** | |
| **Dentist** | | | |

SPECIALISTS YOU HAVE SEEN

| Name | Specialty | Phone Number | Reason for Visit | Date of Last Visit |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Do you have an Advance Directive or Living Will? Yes ☐ No ☐
Do you have a Medical Power of Attorney? Yes ☐ No ☐

**If yes, please provide name of Medical Power of Attorney _____**

## PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices upon request.

Signature_____ Date _____

## CONSENT TO CREDIT BUREAU INQUIRIES

I hereby consent to credit bureau inquires and to receiving auto-dialed/artificial or pre-recorded message calls, and/or text messages to my cellular telephone and to any telephone number provided during my registration process I understand that these collection attempts could be performed by Be Well Primary Care or its affiliates/agents including, without limitation, any account management companies, independent contractors or collections agents.

**Y_____N _____**

**Lab / X-Ray / Diagnostic Services:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

## CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider.
I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

- I further authorize and request that insurance payments be directed to Be Well Primary Care

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment** and **release of medical information & insurance authorization**. I also certify that all of the information, provided is complete and accurate.

Patient Name_____ Signature_____ Date_____

# Practice Policies

Please initial each section after reviewing

_____ No Show Policy:

We ask you to be considerate of the medical needs of others and call our office promptly within 24 hours of your appointment if you are unable to make your appointment time. This allows us to make your appointment available to another patient who needs medical attention.
If you do not arrive for your appointment, or fail to cancel prior to 24 hours before your appointment time, there will be a **$35.00** no show fee applied to your account that will need to be paid in full by the next scheduled appointment time. This fee cannot be billed to your insurance company.

You may be reminded of your upcoming appointment by portal reminder, text, or phone call. Please understand that these reminders regarding your appointment are a COURTESY only, any disputes regarding no shows because of a courtesy call or text "not received" will NOT be waived. You are ultimately responsible.

The doctors make every effort to be respectful of our patients' time and to see our patients on time. Please be aware that if you arrive 15 minutes after your scheduled appointment time, you may be asked to reschedule.

_____ After Hours Calls:

Our office hours are Monday through Friday 8:00am to 5:00pm. We make every effort to return patient calls promptly, usually by end of the business day. After hour calls are defined as calls received after 5:00pm Monday-Friday and all weekends or holidays. These calls will accrue a **$35.00** after hours call fee applied to your account. This fee cannot be billed to your insurance company. For emergencies please visit your closest Urgent Care or ER

_____ Letters/Completion of Forms:

All patient letter requests and form completion will accrue a letter/form fee. Patients will be required to schedule a visit for these request. This fee will be applied to your account. This fee may not be billed to your insurance company. Please allow 48hrs for the physician to complete your form or compose your requested letter.

_____ Payment at Time of Service:

Your insurance company may require a co-pay at every visit. If you have scheduled a well visit but require additional evaluation or tests you may be billed for both a well and "sick" visit. Please check with your insurance carrier for any questions.

_____ Managed Care:

We accept dozens of insurance plans with various deductibles, co-pays, and coverages. We cannot know all of the coverage limitations and rules of your plan. It is important that you read and understand the provisions of your insurance.

_____ Medication Refills:

When you need a refill, please contact your local or mail order pharmacy and ensure they don't have any additional refills before contacting our office. Please request the pharmacy to eScribe request (preferred) or fax our office a refill request. Please allow 24 hours to process refill requests. Requests are not processed after office hours, weekends or holidays.

During your visit your Doctor will give you prescriptions in amounts to last until you need to be seen again. These follow-up appointments are scheduled so that your provider can monitor your condition and adjust medications accordingly. To ensure appointment availability, please make this appointment at the time of your current visit or at the time you get your last refill.

A refill request will be denied if you missed a scheduled appointment, are not current on any laboratory tests required for the medication, or have not had your annual physical exam. If you are stable on your medications the schedule below is followed:

- Diabetic medications require labs drawn every 3 months and exam with provider
- Cholesterol medications require labs drawn every 6 months and exam with provider
- Thyroid medications require labs drawn every 6 months if well controlled.
- Hypertension medications require an exam every 6 months with provider
- An annual physical is required on every patient with a medical condition that is treated in our office

_____ Referrals:

It is the patients responsibility to ensure the referred physicians are covered by their insurance plans. Many insurance plans or specialists office require a referral from your primary care office. Please call your insurance company and let our office know of the specialist covered by your insurance. Once we receive your call, please allow at least 5 business days for our office to process a referral.

_____ _____

Patient's Name (PRINT) Patient Signature/Date

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# Health Information Exchange Authorization

Be Well Primary Care participates in health information exchanges and a copy of Privacy Practices can be available upon request.

A Health Information Exchange (HIE) is an organization that oversees and governs the exchange of health related information among organizations according to nationally recognized standards. A Health Information Exchange is an electronic health information system that stores your patient health information from multiple healthcare providers participating in the HIEs. It allows your other health care providers to view your past health information for continued care and other uses included in the provider's Notice of Privacy Practices. Your information will be stored within the HIE system, but it will not be visible to or able to be used by providers unless you opt-in to participate.

I understand that my medical records are confidential and cannot be disclosed without my written authorization except when otherwise permitted or required by law. I understand that my medical information may include communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment and alcohol and substance abuse diagnosis or treatment, and I authorize release of that information as part of my medical record. Providers will attempt to exclude clearly identified mental health and substance abuse health information from the HIEs, however some information may be included.

I authorize the above provider to disclose my medical information described above to the HIEs in which Be Well participates. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by other providers and such information may no longer be protected.
I understand that treatment or payment cannot be conditioned on my signing this authorization. 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 this authorization. I may submit a revocation request to the above provider for processing. This authorization will remain in effect indefinitely, unless I revoke it in writing. The HIE is not able to manage restrictions on disclosure of your health information. A restriction is a request by the patient to not disclose certain information to certain people or companies. If the restriction is or was agreed to by us or other participating HIE healthcare providers, then you must elect to opt-out of the HIE in order to protect your restriction. This must be done at each HIE participating provider you visit.

I authorize release of my medical information to the Health Information Exchanges in which Be Well Primary Care participates:
_____ Yes _____No

Acknowledgement:
I, the undersigned, certify that I have read and fully understand the information in this Health Information Exchange Authorization form. I understand that if I need to change any information I have provided on this form, I will notify a staff member promptly.

| | | |
|---|---|---|
| Print Patient's Name | Date of Birth | Address |
| Signature of patient or authorized representative | Relationship to patient or self | Date |
| Witness | Title | Date |

A "legally authorized representative" is; 1) a legal guardian, 2) an agent authorized in a medical power of attorney or directive to physicians, 3) an attorney appointed by a court, 4) an attorney retained by the patient or the patient's legally authorized representative, 5) a parent or legal guardian or a minor, or 6) a person authorized under the Texas Consent To Medical Treatment Act: the patient's spouse, adult child, a parent of the adult patient, a person clearly identified in advance of incapacity to act for the patient, the nearest living relative, or a member of the clergy. Written evidence of legally authorized representative status must be presented to the clinic prior to release of any information.

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# Medical Release of Information Form

Patient Name:_____Date of Birth:_____

Social Security #:_____Previous Name: _____

Home Phone:_____Other Phone: _____

Address, City, State, Zip _____

I request and authorize:_____

(Name and Address of Physician and/or Clinic/Practice you want to release yourrecords)

Address: _____

City & State:_____Zip Code:_____Phone:_____Fax: _____

**To release the medical record of the above named patient to:**

## Be Well Primary Care

Radhika Vayani, D.O
3800 N Tarrant Parkway Suite #210
Fort Worth TX 76244
**Phone:** 682-593-6660

**Reason for release (required field):**_____
Health Care information relating to the following treatment condition or dates of treatment:

_____

*This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.*

This request and authorization applies to: (initial appropriate line)

_____All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

_____All Health Care Information excluding information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. Treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.
I understand I have the right to revoke this authorization by providing a written request to the above named physician or organization. I understand that the revocation will not apply to information that has already been released in good faith. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization.

_____ _____
Signature of patient or authorized representative Date

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

I understand that authorizing the disclosure of this health information is voluntary.