North Richardson Family Clinic
3200 Talon Dr. #100, Richardson, TX 75082
Jinsong Zhang MD, PhD

Pre-Appointment Questionnaire

Name: **DOB:**

What is your main purpose in coming to our office today?

Are you experiencing any symptoms?

Personal / Social History

1. What do you do for exercise? _____ How long? _____ How often? _____
2. Do/Did you use tobacco products? Y / N How much? _____
3. Do/Did you use illicit/street drugs Y / N How much? _____
4. Do/Did you drink alcohol? Y / N How much? _____
5. Are you sexually active? Y / N with Females / Males / Both
6. Do you have a history of STD? Y / N Year and Results: _____
7. Have you ever been a victim of physical, verbal, emotional, or sexual abuse? Y / N
8. What was the date of your last complete physical exam? _____
9. List any surgeries or hospitalization reasons and dates:
   - _____
   - _____
   - _____
   - _____
10. When was the last time you had a Tetanus shot (TDap) shot? _____
11. When was your last colonoscopy? _____ Was everything normal? _____
12. (Females) When was your last Mammogram? _____ Was everything normal? _____
13. (Females) When was your last pap smear? _____ Was everything normal? _____
14. (Females) When was your last bone density? _____

Would you like to start losing weight? Y / N
If yes, what is your desired weight?_____lbs

List of Medications

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Do you have any drug allergies? Y / N
List if yes:

Family History:

1. Are you adopted? Y / N
2. Father: Alive (age) _____ Deceased (age) _____ Cause _____
3. Mother: Alive (age) _____ Deceased (age) _____ Cause _____
4. Brother(s): Number Alive (age) _____ Number Diseased (age) _____ Cause _____
5. Sisters(s): Number Alive (age) _____ Number Diseased (age) _____ Cause _____
6. Child(ren): Sons: _____ Daughters: _____

New Patient Forms

North Richardson Family Clinic
Jinsong Zhang MD, PhD

Patient Information

First Name | Middle Name | Last Name | Preferred Name

Home Address (Street, City, State, Zip)

Date of Birth | Home Phone | Cell Phone | Email

☐Male ☐Female ☐Transgender ☐Single ☐Married ☐Divorced ☐Widowed

Parent Information (For Minor's Only)

Mother's Name | Date of Birth | Phone Number | Driver's License No.

Father's Name | Date of Birth | Phone Number | Driver's License No.

Mother's Marital Status | Address

Father's Marital Status | Address

Pharmacy Information (Mandatory for all patients!)

Pharmacy Name | Pharmacy Phone Number

Pharmacy Address (Street, City, State, Zip)

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Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment be sent to other attending Doctors in the future.

- Obtain payment from third-party payers in your behalf, ie... health insurance.

- Conduct normal healthcare operations such as quality assessments and required local/federal certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, financial or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize North Richardson Family Clinic and its employees to contact me with information regarding my appointments, treatment, billing, health, and services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your health care information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed & consent to these notices & release information to the above person(s)

_____ _____

Patient Name Patient/Guardian Signature Date

Financial Policy

North Richardson Family Clinic

Thank you for choosing our office as your health care provider. We are committed to providing you with the highest quality care, so that you may fully attain optimum health. Please understand that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash and card, not checks.

Do You Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your health care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We thank you for the opportunity to serve your health care needs and welcome any questions you may have concerning your care or our financial policy.

MISSED APPOINTMENT AND CANCELLATION POLICY

If you are unable to keep a scheduled appointment please give a **24 hours advance notice**, to ensure that you will NOT be charged for the appointment. If less than a 24 hour notice is given to cancel or reschedule you will be considered a "No-Show" and you will be expected to pay $25 for the appointment. The **$25 "No-Show" charge** will be expected your next visit.

I also understand that if I am greater than 15 minutes late, the office has the option to reschedule you to a different date or time. _____
(Initial)

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY BENEFITS DIRECTLY TO MY PROVIDER'S OFFICE.

Signature _____ **Date** _____
(Patient or Guardian)

PATIENT YEARLY UPDATE FORM

X Patient Name:_____ Patient SS #_____

X Date of Birth:_____ Insurance:_____

Cell Phone:_____ Home Phone:_____

Work Phone:_____ Email:_____

Address:_____City:_____State:_____Zip:_____

Emergency Contact:_____ Phone: _____

Pharmacy:_____ Pharmacy Location: _____

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We are committed to providing excellent and efficient health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of some of our key policies:

PLEASE READ AND INITIAL NEXT TO EACH ITEM:

X _____ Unfortunately, we are unable to adjust our fee schedule or change amounts for high deductible policies. Since we are contracted as an in-network provider with your insurance company, we have to agree and abide by their specific guidelines for our charges and collection of your deductible amount.

X _____ Any outstanding account balances must be paid IN FULL prior to your office visit.

X _____ As a courtesy and convenience for our patients, we draw labwork in our office and submit directly to the lab (True Health, LabCorp and/or Quest) for processing. The Lab will bill your insurance directly and if any balance is unpaid you will receive a bill directly from the lab. As a patient you have the right to decline a specific test or order if you wish. It is ultimately your responsibility to understand your individual insurance policy and which lab test they will and will not pay for. We cannot re-code lab visits and diagnosis codes cannot be changed once submitted. If you have a dispute regarding a lab bill, please contact the lab and/or your insurance company directly.

I attest the contact and insurance information provided is up-to-date and correct. I have also read and understand the policies listed above.

X_____

Patient Signature