GODLEY FAMILY MEDICINE CLINIC
503 Hwy 171 Ste. C
Godley, TX 76044

www.godleyfamilymedicine.com
Tel. 817-389-2307
Fax 817-766-7010

Godley Family Medicine

Date:_____

Patient Information

Last Name:_____ First Name:_____ Middle Initial: _____ Sex: ____

Date of Birth: ____/____/____ Social Security Number: _____-_____-_____ Home Phone: (____) ____-_____

Address:_____ Apt. #_____

City:_____ State: _____ Zip Code:_____

Additional Information

Email:_____

Home Phone: (____) ____-_____ Work: (____) ____-_____

Cell: (____) ____-_____ Other: (____) ____- _____

Employer: _____

Employer Address:_____

Employer Phone: _____

Emergency Contact Name: _____

Relation to Patient: _____

Phone Number: _____

Patient's Marital Status:
Single ___ Married ___ Separated ___ Divorced___ Widowed___

PATIENT'S:
Spouse's Name:_____

Spouse's Date of Birth: ____/____/_____

Insurance Information

Primary Insurance

Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Policy #:_____ Group #:_____

Policyholder:_____

Secondary Insurance

Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Policy #:_____ Group #:_____

Policyholder:_____

Godley Family Medicine

CONSENT TO TREAT – Please read carefully

Patient Name: _____ DOB: _____

CONSENT FOR TREATMENT

I hereby authorized evaluation and treatment by the physicians and staff associated with Godley Family Medicine Clinic. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

_____
Patient (Please Print)

_____ _____
Patient (Signature) Date

CONSENT TO RELEASE INFORMATION TO ANOTHER ADULT
(Over the age of 18)- Please Read Carefully

I hereby authorize _____to receive information on my
Name/Relationship
behalf if I am unable to be reached. I understand that **any** medical advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice and that a photocopy of this form is considered valid as the original.

_____
Patient (Please Print)

_____ _____
Patient (Signature) Date

Godley Family Medicine

GODLEY FAMILY MEDICINE CLINIC

FINANCIAL POLICY– Please Read Carefully

- Copayment, deductible or coinsurance is due at the time of service. We accept Cash, MasterCard or Visa.

- Any balances that are applied to your deductible must be paid in full before the next office visit.

- **WE DO NOT ACCEPT CHECKS.**

- ***24 hour prior notice of appointment cancellation is required***. A **$25.00** cancellation fee will apply after the second cancellation that does not meet our requirements. A **$50.00** cancellation fee will apply after the third cancellation that does not meet our requirements.

- Billing statements are sent out each month. Any balance not covered by your insurance must be paid in full before the next appointment. Unpaid balances over 90 days may be turned into collections, and additional fees will be assessed.

- If your balance is high, due to hospital deductible or financial hardship issues, please meet with the office manager to establish a payment plan option.

- For private pay families, we offer a cash rate discount. Please contact our office for cash rates. **All balances must be paid in full at the time of the service. Please note: NO CHECKS ACCEPTED.**

- **A $25.00 charge for medical records must be paid at the time the records are requested.**

Please note: There will be a charge for after hours calls. The charge will be **$25.00 billed directly to the patient**. This fee is not covered by any insurance plan.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient Name (Signature) Date

Godley Family Medicine

GODLEY FAMILY MEDICINE CLINIC

INSURANCE AUTHORIZATION – Please read carefully

INSURANCE INFORMATION

- As a courtesy to our patients we have enrolled in many managed care programs. However, we do not take responsibility for items that are not covered by your individual plan.
- We will not file any claims for patients without an insurance card. You can request your insurance company to fax or provide you with insurance documentation of coverage that includes all billing information.
- We will not be responsible for any denied claims due to filing deadlines if new insurance is not presented to us at the time of service.
- Prior to the office appointment, please be sure that you have contacted your insurance company to add your new baby/child to the insurance policy. If the claim is denied, you will be responsible for payment.
- It is advised that all patients verify (if not already known) to see if we are a network provider for your insurance.
- Check which lab your insurance company is contracted with.
- Our clinic holds an additional stock of state mandated immunizations available for your child free of charge if you meet the criteria of being underinsured. A $10.00 charge per vaccine administration will apply.

AUTHORIZATION

As a courtesy, Godley Family Medicine Clinic will verify and file insurance, but the practice cannot guarantee payment. I understand that I am financially responsible for services rendered as and when charges are incurred. I hereby authorize Godley Family Medicine Clinic and/or the rendering physicians(s) to release all medical information required by my insurance company to file claims for medical benefits. I authorize payment of all applicable benefits directly to Godley Family Medicine Clinic. This authorization will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. Consent to release information acquired in the course of examination and/or treatment in regards to treatment, payment of services and operations is understood and explained to me in the posted Notice of Privacy Practices.

Patient Name (Please Print) Signature Date

. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Irene Gonzalez at (512) 665-5726 or manager@godleyfamilymedicine.com for further information about the complaint process.

This notice was published and becomes effective on August 1, 2018. If you wish to have a copy of this document for your records, please ask the front desk staff to print you a copy. You may also download a PDF version of this document from our web site: www.godleyfamilymedicine.com

I hereby acknowledge the receipt of "Godley Family Medicine Clinic Notice of Privacy Practices, Version I" and agree to the terms and conditions stated in this document:

This is the only the last page of the Notice of Privacy Practices. If you would like to have a copy of all pages, please let us know or visit our website.

Date of Birth: _____

_____ _____
Patient's Name (Please Print) Date

_____ _____
Patient's Name (Signature) Date

Godley Family Medicine

Godley Family Medicine Clinic
Patient Contract
for
Using Opioid Pain Medication in Chronic Pain

This is an agreement between_____ (the patient) and Joy Keeton, FNP-C and her clinical staff concerning the use of controlled substances and opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The narcotic medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that controlled substances and opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.

2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. The withdrawal from these medications may even cause seizure.
   I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.

3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. '

4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.

5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.

6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.

7. I agree that the opioids will be prescribed by only <u>one</u> doctor and I agree to fill my prescriptions at only <u>one</u> pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for controlled substance/opioid medication or going to other pharmacies.

8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.

9. I agree not to sell, lend, or in any way give my medication to any other person.

10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.

- **Patients requiring chronic pain management will be referred to pain management.**

Agreement - page 2

11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor. A monthly follow up and office visit is required for refilling your medication.

12. I understand that there is a risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient signature

Provider signature

_____

Date

I understand that the medication is prescribed as follows:

Type of medication _____

Number of pills and frequency _____

Total number of pills _____

Next refill due _____

Patient signature **DATE**

Provider signature DATE