Micheal A. Moisant, D.O.
Christopher M. Duhan, M.D.

4412 Kell West Boulevard
Wichita Falls, TX 76309
(940) 696-0011
(940) 696-2248 (Fax)

Dear New Patient,

Thank you for choosing Kell West Family Practice Clinic for your healthcare needs. We are honored you have chosen us to fulfill the important role of caring for you and your family.

Our clinic requires pre-registration for all our new patients. This service allows our nurses to review your health information as well as enables us time to verify all demographic and insurance information prior to your visit thus decreasing your wait time when you arrive for your visit. Please remember that all copayment, deductibles and any other patient responsibilities are due prior to or at the time of service.

Pre-Registration will benefit you by:

- Enabling our nurses and providers an opportunity to review and become familiar with your health history when preparing for your initial visit.
- Allowing us to communicate with your insurance company to verify benefits and eligibility, and resolve any insurance concerns before your appointment.
- Informing you of financial obligations beforehand so you can plan for the unexpected.
- Reducing checkout delays by having this information prior to your appointment.

We offer several options for pre-registration:

- Visit our website at www.kwfpc.com and click on New Patient Pre-registration Packet.
  - Print pre-registration forms and fill out all information.
  - Email, mail or fax all forms along with a copy of your current insurance card (front and back), driver's license, and social security card.
- Visit our office Monday-Friday from 8:00 a.m. to 6:00 p.m. or Saturday 9:00 a.m.-3:00 p.m. and ask for New Patient Pre-registration Packet.
  - Bring all completed pre-registration forms along with current insurance card, driver's license, and social security card.

These options are available for your convenience and one of our friendly office staff will be glad to assist you.

After your initial appointment, please arrive at least 15 minutes prior to any established appointment to fill out any additional medical forms (if required), update any necessary information and submit payment for any co-pay, deductible or coinsurance.

Thank you in advance for your cooperation and we look forward to seeing you on your appointment day.

Sincerely,

KWFPC Staff

Patient Registration Information

Please print and complete all sections below

Patient's Personal Information: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Race: American Indian-Alaska Native-Asian-Black/African American-Native Hawaiian-White-Pacific Islander-More than one race-Refuse to report
Ethnicity: Hispanic or Latino---Not Hispanic or Latino---Refuse to report/unreported
Preferred Language: English---Spanish---Other

Name: _____
Last Name First Name M. Initial

Date of Birth _____/_____/_____ Social Security #: _____ - _____ - _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

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

Driver's License # _____ State issued: _____ Email Address: _____

Guarantor of Account Relationship to Patient: ☐ Self ☐ Spouse ☐Child ☐ Parent ☐ Other _____

Name: _____Date of Birth _____/_____/_____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Employment Information: ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Employer: _____ Occupation: _____

Work Phone: (_____)_____ Address: _____

Insurance Information: Please present insurance cards to receptionist.

Primary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Secondary Insurance Name: _____

Group # _____ Policy # _____ Copay $_____

Name of cardholder: _____ Date of Birth _____/_____/_____ SS # _____-_____-_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

How were you referred to KWFPC? Television_____ Website_____ Social Media/Facebook/Twitter_____
Family/Friend____ Magazine____ Word of Mouth____ Walk-In____ Other, Please Explain_____

Emergency Contact:

Name: _____ Relationship: _____

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

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Kell West Family Practice Clinic, and any assisting physicians for services needed. I understand that I am financially responsible for all charges whether of not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature Date

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KELL WEST
FAMILY PRACTICE CLINIC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Kell West Family Practice Clinic. For example, information on the services you received may be used to support budgeting, financial reporting, and quality initiatives.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate a law-enforcement investigation, and to comply with government-mandated reported.

Public Health Reporting: Your health information may be disclosed to public health agencies, as required by law. For example, we are required to report certain communicable diseases to the state's health department.

Other: Other uses and disclosures of your health information require your authorization. Disclosure of your health information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use of your information, you may submit a written revocation of the authorization. However, you decision to revoke the authorization will not affect or undo any uses or disclosures of information that occurred before you notified us of your decision to revoke authorization.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders

Information about Treatment: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services which we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. They include the following:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Kell West Family Practice Clinic Duties

By law, we are required to maintain the privacy of your personal health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulations, we require a written request to inspect or copy protected health information. You may obtain a form to request access to your records by contacting the Compliance Officer or one of our receptionists.

Contact

The name and address you can contact for further information concerning our privacy practices are listed below. If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to the following:

Compliance Officer
Kell West Family Practice Clinic
4412 Kell Boulevard
Wichita Falls, TX 76309

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

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HIPAA AUTHORIZATION FORM

I, _____, give permission to Kell West Family Practice Clinic to:

☐ use the following protected health information, and/or

☐ disclose the following protected health information to:

Names of entity or Person to receive information:

_____
_____
_____

Information to be disclosed (check all that apply):
☐ Medical Records
☐ Treatment Records
☐ Diagnostic Records
☐ Other: _____
_____
_____

This protected health information is being used or disclosed for the following purposes:
_____
_____
_____

This authorization expires on __/__/____.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment of your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification to Kell West Family Practice Clinic at 4412 Kell Blvd., Wichita Falls, TX. 76309. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

KELL WEST FAMILY PRACTICE CLINIC
FINANCIAL POLICY

Thank you for choosing Kell West Family Practice Clinic for your healthcare needs. This policy was created to outline our expectations of you regarding your financial responsibilities to this clinic.

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

As a patient of Kell West Family Practice Clinic you will be required to sign a financial responsibility form. Payment is required at the time services are rendered unless other arrangements have been made in the advance. Patients with an outstanding balance must make arrangements prior to scheduling appointments. **Any two consecutive months without payment or contact with the billing department will cause the remaining balance to be turned over to collections.**

INSURANCE

We bill participating insurance *companies* as a courtesy service to you. You are expected to pay your ***deductible and co-payments or coinsurance*** at the time of service. On occasion, your insurance may determine that the services you received are not covered. ***Please read your insurance handbook and be aware of services that are considered non-covered***. When in doubt, contact your insurance company directly for clarification. You will be responsible for services not covered by your insurance plan. If we do not receive payment from your insurance company within 90 days of the claim filing date, patients will be expected to pay the balance in full.

SELF-PAY PATIENTS

Self-Pay patients and patients who present without proof of insurance for verification are required to pay for services in full at the time services are rendered. Also, *a $75.00 deposit is required* at the time of check-in. We understand that affordable insurance coverage is not readily available for all of our patients. We also realize the lack of insurance coverage may determine the level of care that individuals seek for themselves or their families. Bearing that in mind, our Self-Pay policy includes discounted rates for our services. If circumstances make it impossible to pay in full at the time of service, we require a minimum payment of $75.00. Any charges not paid on the date services are rendered will NOT receive the Self-Pay discount. **PLEASE NOTE YOUR BALANCE TODAY IS AN ESTIMATE OF YOUR CHARGES. YOU MAY STILL RECEIVE A BILL FOR SERVICES RENDERED.**

FORMS OF PAYMENT

We accept Cash, Checks, Visa, MasterCard and Discover. .

RETURNED CHECKS

All returned checks are handled through Check Net. Any returned check must be taken care of prior to scheduling an appointment. In the event of a second returned check, this method of payment will no longer be accepted.

APPOINTMENTS

If at any time you are unable to make your appointment, please notify us at least 24 - 48 business hours in advance. We would be glad to reschedule your appointment at a more favorable time, if necessary. We greatly appreciate your time and consideration and look forward to seeing you.

I have read and understand the Kell West Family Practice Clinic's Financial Policy.

Printed Name of Insured or Authorized representative:

_____

Signature of Insured or Authorized representative: **Date:**

_____ _____

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KELL WEST
FAMILY PRACTICE CLINIC
My Health, *My* Family, *My* Doctor

Patient Notification Regarding Radiology and Laboratory Services

Please be advised that if you receive any technical services such as x-rays and pathology, you will be billed the professional services by other providers as well. For example, your pathologist and radiologist **(those who interpret lab and x-rays)** bill separately from our clinic and may not participate in the same health plans as Kell West Family Practice Clinic. You will be responsible for paying these providers subject to the terms of your health plan or insurance, if any. Additionally, Clinical Pathology Laboratories, INC. and Boston Heart Diagnostics® which are outside laboratories, will bill for all lab services. If you have questions regarding these bills please call the billing number located on the statement you received.

Printed Name of Patient: _____

Signature of Patient or Authorized Representative: _____

Date: _____

HISTORY Name:_____DOB_____Date:_____

Do you have any of these medical problems? If **YES** please circle.

Eyes - cataracts, glaucoma, glasses/contacts, macular degeneration, other_____
Ear, Nose & Throat - allergies, sinusitis, dental abscess, swollen glands, chronic sore throat, TMJ
Heart - high blood pressure, irregular heart beat, heart failure, heart attack, CAD
Lungs - asthma, emphysema, COPD, pneumonia, sleep apnea, cancer
Stomach & Intestines- reflux, ulcers, irritable bowel, diverticulosis, constipation, cancer
Urinary - urine incontinence, prostate disease, sexually transmitted disease, kidney stones
Muscles & Joints - arthritis, pain in arms/legs/neck/back, radiating pain
Brain & Nerves - seizures, headache, migraines, stroke, Parkinsonism, dementia
Skin - acne, eczema, psoriasis, hives, cancer, other _____
Hormones - diabetes, thyroid, high cholesterol, menopausal, osteoporosis, gout
Blood - anemia, bleeding, blood clots, cancer
Psychiatric - depression, anxiety, bipolar, schizophrenia, other _____

Have you had any surgeries? If **YES** please circle and note **WHEN (dd/mm/yy)** or **AGE**.
Tonsils, Appendix, Gallbladder, Uterus, Ovaries, Heart, Colon, Hip, Knee, Prostate, Breast, Back, Other

Please list other physicians who provide care for you._____

Are you currently taking any medicines? If **YES** please write them below, or provide a current list

Name of Medicine	Medicine Dose	How many times each day?	For what condition?

Are you allergic to any medications? If **YES** please write them below.
1._____ 2. _____ 3. _____
4._____ 5. _____ 6._____

Family's Medical History

Father Living or Deceased Age_____Medical problems_____
Mother Living or Deceased Age_____Medical problems_____
Sibling 1 (B/S) Living or Deceased Age_____Medical problems_____
Sibling 2 (B/S) Living or Deceased Age_____Medical problems_____
Sibling 3 (B/S) Living or Deceased Age_____Medical problems_____
Sibling 4 (B/S) Living or Deceased Age_____Medical problems_____

Social History Information

Are you adopted? (Y/N) Employed or Retired? Occupation_____
Married (Y/N) Widowed (Y/N) Divorced (Y/N)_____ Do you have children? (Y/N) _____

Do you Smoke? (Y/N) Did you use to smoke? (Y/N) How many packs?_____
How Long?_____ Quit? (Y/N) When? _____ Smokeless Tobacco (Y/N)

Do you drink alcohol? (Y/N) Did you use to drink alcohol? (Y/N) What kind?_____
How Often?_____ Quit? (Y/N) When? _____ Attend AA? (Y/N)
Substance Abuse? (Y/N) What?_____ When?_____ How Long? _____ Quit? (Y/N)

Office Use Only

Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____

REVIEW OF SYSTEMS Name:_____ DOB_____ Date:_____

Please circle each symptom you have experienced in the past thirty (30) days.

General	weight loss, weight gain, fatigue
Eye	blind spots, double vision, pain with sun light, red eyes
Ear, Nose & Throat	hearing loss, ringing, dizziness, pain, runny nose, nose bleeds, sinus drainage, difficult or painful swallowing, hoarseness, mouth sores, bleeding gums, allergies
Heart	chest pain, pounding heart, racing heart, shortness of breath, difficulty breathing, swelling, blue fingers or lips
Lungs	wheezing, difficulty breathing, cough, night sweats, short of breath, pneumonia, bronchitis
Stomach & Intestines	pain, nausea, vomiting, diarrhea, constipation, heartburn, bloody/black stool, hemorrhoids, change in bowel movements
Urine	painful urination, frequent urination, bloody urine, leaking urine, cloudy urine, waking up to urinate Male: hernia, difficulty with erection, penile discharge Female: vaginal discharge, painful intercourse
Muscles & Joints	pain, numbness, tingling, weakness, clumsiness, swelling
Brain & Nerves	headache, fainting, shaking, tremor, clumsiness, dizziness, numbness, tingling, falling, memory loss
Hormones	eating a lot, drinking liquids a lot, tremor, night sweats,
Blood	easy bruising, easy bleeding, nodes/glands enlarged, varicose veins
Skin	rashes, lesions, moles, finger/toe nail problems
Psychiatric	sadness, stress, guilt, depression, anxiety, crying, nerves, suicidal thoughts, appetite changes, agitation
Other	anything else not listed above _____

Women Only--Please answer the following questions:

Last menstrual period _____
Age when periods started _____
Number of Pregnancies _____
Are you currently pregnant? _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
Age at Menopause _____
Menstrual Period: Regular or Irregular Light / Moderate / Heavy
_____# days bleeding every _____ days

Office Use Only

Rec: _____ Date: _____ Nurse: _____ Date: _____ Provider:_____ Date:_____

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Elizabeth Vu, P.A.

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KELL WEST
FAMILY PRACTICE CLINIC

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me. Please release a copy of my medical records or a summary or narrative of my protected health information to the person(s) or entity listed below.

*Patient Name: _____

*Social Security Number: _____ *DOB: _____

Records to be sent from the following facility:

*Physician's Name/Clinic: _____

*Address: _____ *City, State, Zip: _____

*Phone: _____ *Fax: _____

Limitations:

☐ Complete record

☐ Records of care from the following dates: _____ to _____

☐ Records concerning the following conditions: _____

☐ Confer orally with person(s) or entity listed below about my medical information.

☐ Other, please specify: _____

HIV/AIDS: I consent to the release of any positive or negative test result for HIV or AIDS infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _____ Date: _____

*Release my protected health information to the following person(s) or entities:

☐ Kell West Family Practice Clinic
4412 Kell Boulevard
Wichita Falls, TX 76309
940.696.0011 Fax: 940.696.2248

☐ Other: _____
Address: _____
_____
Phone: _____ Fax: _____

*The reason or purpose for this release of information is _____

I understand you will provide this information within fifteen days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

*Patient Signature (or parent, guardian, or legal representative): _____ Date: _____

*MUST BE COMPLETED IN FULL.