Administrative
and Business Center
9003 Airport Freeway
Suite 300
N. Richland Hills, TX 76180

Office (817)514-5200
Fax (817)514-5210 CBO

Hello,

On behalf of the nurses, physicians and staff of **Medical Clinic of North Texas** (MCNT), I would like to take this opportunity to welcome you to our group. I am delighted you chose one of our physicians to care for you or your loved ones. We are all personally committed to providing the highest quality care and exceptional customer service for you and your family.

Our network of physicians is unique to the Dallas-Fort Worth Metroplex because we focus on providing primary care through the following specialties: Pediatrics, Family Medicine, Internal Medicine, Obstetrics & Gynecology, Sports Medicine and Rheumatology. This allows us the ability to serve you and your family at every stage of your lives.

With more than 100 physicians and 37 locations, MCNT physicians are conveniently located to meet your personal health care needs. In addition, we strive to be progressive in our use of Information Technologies to include electronic medical records and on-line services. Our advanced systems provide you easy access to our physicians for appointments and timely medical advice.

For more information, please review our web site at www.MCNT.com. Again, thank you for choosing your Medical Clinic of North Texas physician.

Sincerely,

Karen Kennedy
Executive Administrator

www.MCNT.com

Medical Clinic of North Texas, P.A.
Acknowledgement of Receipt of
Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the Medical Clinic of North Texas, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website, www.mcnt.com, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

______________________________	______________
Patient's Printed Name	Date of Birth
______________________________	______________
Patient/Legal Representative Signature	Date
______________________________	
Relationship to Patient	
______________________________	______________
Witness	Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Medical Clinic of North Texas, P.A., P.A. to share my protected health information with:

______________________________	______________
Name	Relationship
______________________________	______________
Name	Relationship
______________________________	______________
Name	Relationship

PATIENT INFORMATION FORM

PHYSICIAN'S NAME ____________________

PATIENT'S FULL NAME				MAIDEN NAME	
MAILING ADDRESS		APT. NO.		PHONE NUMBER	( )
CITY	STATE	ZIP		BUSINESS PHONE	( )
SEX ☐ F ☐ M	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER ______ ☐ DIVORCED ☐ WIDOWED	DATE OF BIRTH		PATIENT'S SOCIAL SECURITY NO.	
PATIENT'S EMPLOYER'S NAME				PATIENT'S E-MAIL ADDRESS	
EMPLOYER'S ADDRESS					
SPOUSE/GUARDIAN NAME	WORK PHONE #	DATE OF BIRTH		SOCIAL SECURITY NO.	
EMPLOYER				ADDRESS	
IN CASE OF EMERGENCY CONTACT		RELATIONSHIP		PHONE NUMBER	( )

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY		INSURED DOB	☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	______	
NAME OF INSURED				COPAY AMOUNT	
INSURED'S EMPLOYER					
INSURANCE CLAIMS ADDRESS				INSURANCE PHONE NO.	( )
CITY		STATE		ZIP	
POLICY NUMBER		GROUP NUMBER		INSURED'S SOCIAL SECURITY	

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY		INSURED DOB	☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER	______	
NAME OF INSURED				COPAY AMOUNT	
INSURED'S EMPLOYER					
INSURANCE CLAIMS ADDRESS				INSURANCE PHONE NO.	( )
CITY		STATE		ZIP	
POLICY NUMBER		GROUP NUMBER		INSURED'S SOCIAL SECURITY	
ANY OTHER INSURANCE COVERAGE	☐ YES ☐ NO	COMPANY NAME		PHONE NUMBER	( )
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				PRIMARY CARE PHYSICIAN	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize The Medical Clinic of North Texas, P.A. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to The Medical Clinic of North Texas, P.A. I understand that I am ultimately responsible for all services whether covered by insurance or not. I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

DATE: ____________________ SIGNATURE ______________________________

Form 10983 (Rev. 02/02)

THE MEDICAL CLINIC OF NORTH TEXAS

PATIENT HISTORY FORM

WE STRIVE TO KEEP ALL INFORMATION IN CONFIDENCE DATE TODAY: ________.
AND WILL NOT RELEASE WITHOUT SIGNED CONSENT. It may be sent to consultants, if referred.

NAME:________________________________ Birth date: ____________ AGE: ________
LAST FIRST M.I.

MARITAL STATUS: ( ) SINGLE; ( ) MARRIED; ( ) WIDOWED; ( ) SEPARATED; ( ) DIVORCED
OCCUPATION:

REASON FOR VISIT Today:

LAST MEDICAL EXAM:
LAST DOCTOR:
LAST CHEST X-RAY (Date and location)

ALLERGIES (DRUGS, X-RAY DYE, TAPE, LATEX)/ & type of reaction:

PHARMACY NAME & #: ________________ **"Have available for calls that may require meds".**

MEDICATIONS: (LIST ALL INCLUDING ONES NOT PRESCRIBED. such as alternative agents or herbal agents).

DRUG	STRENGTH	HOW OFTEN YOU TAKE PER DAY	LENGTH OF TIME YOU HAVE TAKEN
i.e. Advil	200 mg.	3 times per day	6 months

Please know what drugs and doses you take; if you need refills let the nurse know whe she places you in the exam room.

CHILDHOOD ILLNESSES: Chicken Pox ( ). Measles/Rubeola ( ). Mumps ( ). Rubella ( ). Scarlet fever ( ).

PREVIOUS MEDICAL ILLNESS/HOSPITALIZATION (other than under surgery):

***If Diabetic**, do you self-test with glucose meter?________ ; do you get yearly eye exams? ____;have you been to a self-management course?_____ ; do you know what to do for low blood sugar?_____; foot care?_____; HgbA1C current value?

SURGERY: (IF YES, PLEASE CHECK (x) AND GIVE APPROXIMATE DATE IN BLANK SPACE)

( ) Appendectomy________ ( ) C-Sections ________ ( ) Hernia repair ________
( ) Breast Biopsy________ ( ) Gallbladder ________ ( ) Hysterectomy________ ( ) Ovary R L ________
( ) Carotid artery________ ( ) Heart angioplasty________ ( ) Mastectomy________ ( ) Stomach surgery________
( ) Cataracts ________ ( ) Heart bypass ________ ( ) Prostate removal ________ ( ) Tonsillectomy ________
Other surgery not listed:

OB/GYN History: Pregnancies: #________. Deliveries: #________ . Last menstrual cycle: ________

****Check _____ if YES or Write NO, infront of items that follow below.**

_____**Tobacco Use** currently? _____# of packs per day: ____________ ; # of years: ________
Are you interested in stopping? (Y_____) (N_____)
_____**Tobacco Use in past?** When did you stop?
If you continue to smoke, exercise regularly! When ready to stop, call if you want help.

_____**Alcohol Use?** Beer_____ ; Wine _____; Mixed Liquor_____. Oz (or glasses or cans per week average): _____
*** Do not mix drinking and driving please. ***

_____**Caffeine Use?** Coffee cups per day: Sodas per day:

_____**Exercise regularly?** Type:________________ ; Times per week: ________
*** Goal of 30 minutes of walking-type exercise 5 days per week recommended. ***

PATIENT HISTORY FORM

DATE ____________________.

NAME: ____ ___________________________.

Last First M.I. Date of Birth

FAMILY HISTORY: Check the box (x) next to the condition that your family member has; then specify their relation to you after the disease, using the abbreviations as follows:

Mother (**M**), Father (**F**), Brother (**B**), Sister (**S**), Grandparent (**GP**), Aunt (**A**), Uncle (**U**)

For example, if your Aunt and Mother had breast cancer (x) *BREAST CANCER* *A,M*

( ) Alcoholism	( ) Colon Polyps	( ) High Blood Pressure	( ) Prostate cancer
( ) Anemia	( ) Colon cancer	( ) Iron Disease	( ) Seizures
( ) Asthma	( ) Diabetes	( ) Kidney Disease	( ) Thyroid disease
( ) Arthritis	( ) Glaucoma	( ) Mental Illness	( ) Tuberculosis
( ) Bleed easily	( ) Gout	( ) Migraine	
( ) Breast Cancer	( ) Heart Disease	( ) Osteoporosis	

	LIVING	AGE OR AGE AT DEATH.	Present health or cause of death
FATHER	( ) Yes, ( ) No	________________	________________
MOTHER	( ) Yes, ( ) No	________________	________________
SIBLINGS			

Immunizations: (Please check the disease against which you have been immunized and date of last booster.) "**Tetanus or Td booster is due every 10 years**." Let the nurse know if you are due for a booster.

( ) Hepatitis B_____ ; ( ) Tetanus ______ ; ( ) Measles/Mumps/Rubella ________

( ) D.T. (Diphtheria/Tetanus)______ ;

( ) Pneumonia _____ ; ( ) Hepatitis A ________ ; ( ) Flu vaccine________ ;

( ) Varicella ______ ; ( ) Meningitis vaccine ________ ;

***If you have Hepatitis C or chronic liver disease, talk to your doctor about keeping up to date with your shots. You may benefit from Hepatitis A or B vaccine, or even the Pneumonia shot.

***If you have lung disease, keep up to date with the Influenza and Pneumonia shots.

Illicit Drugs Use? Please discuss with your physician.

Risk factors for AIDS & Hepatitis B and C are the following. If any apply, please let your physician know during your visit. We will observe confidentiality.

Blood transfusion; Homosexual relations; IV Drug use; Relations with IV Drug user; Needle Sticks; Work with body fluids, such as dental work, nursing, ER, etc., or Sex with multiple partners.

Check ______ If YES or Write NO, for items that follow.

_____ **Diet:** Are you interested in information on diets for weight or cholesterol or diabetes?

_____ **Calcium intake:** Do you know women need about 1000mg. of calcium intake per day?

_____ **Bone Density tests:** check if interested in information; considered after age 50 in women.

_____ **Colon exams:** Did you know most experts recommend a colon exam every 5 years, after age 50? Please let us know if you have a family history of colon cancer.

_____ **Mammography:** recommended yearly in women after age 40; check if due for this test.

Safety Measures: Examples of action you can take are: Seat belts (every time), bicycle helmets (even adults), wrist protection during roller-blading, eye protection (weed-eating, power sawing, etc.), proper gun use (locking, unloading, keeping out of children's access).

Advanced Directives: **Please discuss with your spouse or family and your physician.**

Living Will? No ( ); Yes ( ). Organ Donor? No ( ) Yes ( );

Durable Power of Attorney for Health Care? No ( ); Yes ( ). Who?

THE MEDICAL CLINIC OF NORTH TEXAS

PATIENT HISTORY FORM

NAME ______________________________

LAST NAME **FIRST NAME** **DOB/MM/YY** **DATE**

PLEASE PLACE A **Y BY THE CURRENT COMPLAINT** OR ALIMENT THAT APPLIES TO YOU. IF UNSURE, PLACE A QUESTION MARK (?) IF IT DOES NOT APPLY, PLACE AN **N**.

HEAD
- _____ BLURRED VISION
- _____ **LAST EYE EXAM** DATE
- _____ GLAUCOMA
- _____ FREQUENT HEADACHES
- _____ MIGRAINE HEADACHES
- _____ LUMPS OR SWELLING IN NECK
- _____ CONSTANT RINGING IN EARS
- _____ HEARING PROBLEMS
- _____ FREQUENT EARACHES
- _____ FREQUENT NOSEBLEEDS
- _____ SINUS INFECTION
- _____ ALLERGIES/HAY FEVER
- _____ HOARSE VOICE, PERSISTENT
- _____ MOUTH OR TONGUE SORES

LUNGS
- _____ ASTHMA
- _____ HAVE COUGHED UP BLOOD
- _____ INCREASING SHORTNESS OF BREATH WITH ACTIVITY
- _____ EMPHYSEMA
- _____ HISTORY OF TUBERCULOSIS
- _____ CHRONIC COUGH

HEART
- _____ FREQUENT IRREGULAR HEART BEAT
- _____ CHEST PAIN OR TIGHTNESS IN CHEST
- _____ HEART MURMUR _____ Mitral valve prob.
- _____ HISTORY OF ENLARGED HEART
- _____ SHORTNESS OF BREATH AT NIGHT
- _____ SWELLING OF FEET, ANKLES PRESENT AFTER SLEEP
- _____ HISTORY RHEUMATIC FEVER
- _____ HIGH BLOOD PRESSURE
- _____ PREVIOUS **HEART ATTACK**

ABDOMEN
- _____ FREQUENT HEARTBURN
- _____ DIFFICULTY OR PAIN IN SWALLOWING
- _____ HAVE VOMITED BLOOD
- _____ RECTAL PAIN OR BLEEDING (BLACK OR BLOODY)
- _____ RECENT CHANGE IN BOWEL HABITS
- _____ DIVERTICULITIS or DIVERTICULOSIS
- _____ **COLON POLYPS**
- _____ **Last Colon exam date:**
- _____ HEPATITIS / YELLOW JAUNDICE/
- _____ LIVER DISEASE
- _____ NAUSEA
- _____ CONSTIPATION
- _____ DIARRHEA; how many per day _____
- _____ ABDOMINAL PAIN WITH Fatty Food
- _____ SUSPECT ULCERS
- _____ HEMORRHOIDS
- _____ HISTORY OF ULCERS
- _____ BLEEDING

NEURO
- _____ LOSS OF APPETITE
- _____ SEIZURE
- _____ LOSS OF CONSCIOUSNESS
- _____ DOUBLE VISION
- _____ MEMORY LOSS
- _____ NUMBNESS OF HANDS OR FEET
- _____ NERVOUSNESS AFFECTING HOME LIFE OR WORK
- _____ SPEECH PROBLEMS
- _____ STROKE

KIDNEY
- _____ RECURRENT URINARY TRACT INFECTION
- _____ URINATION AT NIGHT MORE THAN ONCE
- _____ BROWN, BLACK OR BLOODY URINE
- _____ BURNING ON URINATION
- _____ KIDNEY STONES
- _____ DIFFICULTY STARTING STREAM
- _____ PROBLEMS WITH SEXUAL FUNCTION
- _____ URINARY INCONTINENCE

JOINTS
- _____ BACK TROUBLE
- _____ SWOLLEN JOINTS
- _____ FREQUENT PAINFUL FEET
- _____ FREQUENT SHOULDER PAIN
- _____ FREQUENT OR PERSISTENT ACHING OF MUSCLES OR JOINTS
- _____ GOUT
- _____ ARTHRITIS
- _____ OSTEOPOROSIS-How diagnosed?

GENERAL
- _____ DIABETES: Date diagnosed: _____
- _____ WEIGHT LOSS GREATER THAN 10 LBS IN LAST YR
- _____ LOSS OF INTEREST IN EATING
- _____ SLEEPING DIFFICULTY
- _____ HERPES IN PAST-genital or face
- _____ THYROID PROBLEMS
- _____ BLOOD PRESSURE PROBLEMS
- _____ MOLE OR SORE NOT HEALING
- _____ HOT OR COLD NATURED
- _____ SUSPECT SERIOUS DISEASE OR CANCER
- _____ LEG CRAMPS WHILE WALKING
- _____ MORE THIRSTY LATELY
- _____ FATIGUE
- _____ FREQUENT CRYING SPELLS, DEPRESSION
- _____ WORK OR FAMILY PROBLEMS
- _____ ANXIETY
- _____ ANEMIA
- _____ HIGH CHOLESTEROL & last result _____
- _____

MALES ONLY
- _____ WEAK URINE STREAM
- _____ PAINFUL OR SORE GENITALS (PRIVATES)
- _____ PROSTATE TROUBLE
- _____ HARD TO EMPTY BLADDER COMPLETELY
- _____ **PERFORM SELF TESTICLE EXAM MONTHLY**
- _____ **LAST PSA TEST (if over age 50)**. DATE _____

FEMALES ONLY
- _____ LAST MENSTRUAL PERIOD _____
- _____ VAGINAL DISCHARGE OR PROBLEMS
- _____ PAINFUL OR SORE GENITALS (PRIVATES)
- _____ LUMPS OR PAIN IN BREASTS
- _____ IF YOU SEE A GYNECOLOGIST, LIST NAME
- _____ **Last Bone Density Test** _____
- _____ **LAST MAMMOGRAPHY.** Date _____
- _____ **LAST PAP SMEAR.** Date _____
- _____ **PERFORM SELF BREAST EXAM MONTHLY**

Medical Clinic of North Texas, P.A.
Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals he or she deems appropriate to perform and/or order exams, tests, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to the Medical Clinic of North Texas, P.A. unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to the Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or body fluids, such as through a needlestick (any such test shall be conducted pursuant to the Medical Clinic of North Texas, P.A.'s infectious disease protocol); or 3)if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested, at the expense of the Medical Clinic of North Texas, P.A. if any of these situations occur during your treatment period.

____ ____________________
Patient's Printed Name Date of Birth

____ ____________________
Patient/Legal Representative Signature Date

____
Relationship to Patient

____ ____________________
Witness Date

MEDICAL CLINIC OF NORTH TEXAS, P.A.
FINANCIAL POLICY

Thank you for choosing the Medical Clinic of North Texas, P.A. (MCNT) as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
  - We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
  - Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.
  - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
  - Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

- **It is your responsibility to provide us with your most current billing information.**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
  - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call **(817)514-5200** or **1-800-555-1429**.
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
  - If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
  - If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at the Medical Clinic of North Texas, P.A. Failure to accept this certified letter (and/or to pick it up at the post office) serves as notice of termination of services.
  - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
  - We may charge you a "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.
  - **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. I have read and understand this Financial Policy.

Signature of Responsible Party   Date

Patient Name: ___________________________   Patient Date of Birth: ___________________________

EPM Medical Record Number: _________________________

Medical Clinic of North Texas, P.A.

Authorization to Release Medical Information to The Medical Clinic of North Texas, P.A.

I, ____, hereby authorize
(Name of patient or legal representative)

Previous Physician's Name: ______________________________

Street Adress: ______________________________

City, State, Zip: ______________________________

to disclose the following information by ☐ mail ☐ fax ☐ electronically or ☐ orally to:

Name: The Medical Clinic of North Texas, P.A./ ____________________

Address:

City, State, Zip:

Phone Number: Fax Number:

From the health records of: ____________________ ____________________
(Name of person whose record will be disclosed) (Social Security Number)

For the purpose of: ______________________________

My authorization extends only to those data elements/documents marked below:

☐ **All records**
☐ Statements of charges or payments
☐ Records of all visits
☐ AIDS or HIV information
☐ History and Physical Examination
☐ Record of visit for a specific date(s).
☐ Progress Notes
☐ Discharge Summary
☐ Consultation Reports
☐ Hepatitis information
☐ Photographs, videotapes, digital, or other images

Specific dates include or are limited to: ______________________________
☐ Copies of records or reports provided to the above named (i.e., hospital, lab, clinic, etc.)
☐ Mental health and/or alcohol and drug abuse treatment
☐ Other (must be specific)

____

(OVER)

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. The Medical Clinic of North Texas, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule.
6. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Patient's Printed Name	Date of Birth
Patient/Legal Representative Signature	Date
Relationship to Patient	Expiration Date of Authorization
Witness	Date