

Patient _____

Alcohol Use Screening Audit C

Did you have a drink containing alcohol in the past year?

- Yes
 No

If Yes: How often did you have a drink containing alcohol in the past year?

- Never
 Monthly or less
 Two to four times in a month
 Two to three times per week
 Four or more times a week

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2 3 or 4 5 or 6 7-9 10 or more

If Yes: How often did you have six or more drinks on one occasion in the past year?

- Never Less than monthly Monthly Weekly Daily

Depression Screening PHQ2

Please indicate the answer that best describes you during the past two weeks:

Do you have little interest or pleasure in doing things?

- Not at all
 Several Days
 More than half the days
 Nearly every day
 Decline to Specify

Feeling down, depressed or hopeless?

- Not at all
 Several Days
 More than half the days
 Nearly every day
 Decline to Specify

Tobacco Control

Non Smoker

Chews Tobacco

Former Smoker YOU MAY STOP HERE IF YOU DO NOT CURRENTLY SMOKE.

Current Smoker everyday some days, but not every day

5 or less 6-10 11-20 21-30 31 or more

After you wake up when do you smoke your first cigarette 5 min 6-30min 31-60min after 60

Are you interested in quitting? Ready to quit Thinking about quitting Not ready to quit

Sexual History

Have you had sex in the last 12 months? (vaginal, oral or anal)? Yes No

With Men Only Women Only With Both Men & Women

Do you use protection? Yes No

Type of Birth Control: _____

Have you ever had an STD or STI? Yes No

Chlamydia? Yes No

Gonorrhea? Yes No

Syphilis? Yes No

Herpes? Yes No

Other? Yes No

DATE ____/____/____

PATIENT NAME _____
Address _____ LAST FIRST MIDDLE (MAIDEN NAME IF MARRIED FEMALE) State Zip

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

DATE OF BIRTH ____/____/____ MALE FEMALE Single Married Divorced Widowed Separated

SSN _____ - _____ - _____ [] Retired [] Disabled Occupation _____

Employer _____ Full Time Part Time Temporary

Employer Address _____ City State Zip

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PLEASE CIRCLE ANSWERS FOR THE FOLLOWING INFORMATION: Language: English Espanol Other _____

Race: White Hispanic American Indian Asian Black Other: _____

Ethnicity: Choctaw Cherokee Hispanic Non-Hispanic Other: _____

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If patient is a minor, under 18 or student under 21, please provide the following Parental/Legal Guardian Information

Responsible Party/Legal Guardian _____ SSN _____ - _____ - _____
LAST FIRST MIDDLE

Date of Birth ____/____/____ Address Same or _____ City State Zip

Relationship to Patient Father Mother Legal Guardian Other-describe _____

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

Employer _____ Occupation _____

Employer Address _____ City State Zip

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INSURANCE INFO – COMPLETE ONLY IF PATIENT IS NOT THE INSURED or IF MINOR IS COVERED BY PARENTS INSURANCE

Insurance Company _____ Spouse Parent Other
Relationship to Patient

Name of Insured _____ /____/____ - _____ - _____
LAST FIRST Date of Birth Social Security Number

Does the Patient live with the Insured? [] Yes [] No - If NO complete the following as it relates to the INSURED

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

Address of Insured _____
Address/P O Box City State ZIP

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PREFERRED PHARMACY – Please Circle One: Corner Drug Durant Medical Supply & Pharmacy

Medical Center Pharmacy Medicine Store Pruett's Walgreens

Wal-Mart-Durant WalMart-Madill OTHER: _____

Please take the time to fill out the forms we require. Filling these forms out carefully is very important, the information you provide us may affect your diagnosis, treatment, prognosis and the quality of the result we will achieve in treating your condition and/or obtaining payment from your insurance company. If any of the information contained on these forms changes in the future, please call us and notify us of the change.

PATIENT AGREEMENTS

ASSIGNMENT OF BENEFITS I hereby authorize and assign third party medical and/or liability benefits directly to DURANT FAMILY MEDICINE CLINIC for benefits due for services rendered. I understand that I am financially responsible for charges not covered by this authorization.

DATE ____/____/____

SIGNATURE _____

Person Responsible for Payment

PAYMENT/DEFAULT I understand that payment is due at the time offices services are rendered. As a courtesy insurance claims will be filed on my behalf by DURANT FAMILY MEDICINE CLINIC. I agree to pay 100% of the patient responsibility upon receipt of billing and/or verbal notification of said balance by DURANT FAMILY MEDICINE CLINIC. In case of default of payment for medical services, I hereby agree to pay any and all collection fees. A billing fee may be charged to cover monthly statements, and I acknowledge that this is my sole responsibility.

PLEASE INITIAL _____

I acknowledge Insufficient (NSF) and Closed Account Checks Will Be Prosecuted To The Fullest Extent Of The Law. NSF Returned Checks are Subject to a Collection Fee Not To Exceed \$100.00. Should a check be returned to this office by the bank unpaid, I agree that I am responsible for the check as well as the collection fee. If the check is collected at the bank I agree to pay the collection fee.

PLEASE INITIAL _____

MEDICARE PATIENT I agree to pay the Federally mandated Medicare copayment at the time service is rendered. Supplemental insurance claims will be filed by DURANT FAMILY MEDICINE CLINIC, however, deductibles and copayments are my responsibility.

PLEASE INITIAL _____

MANAGED CARE PATIENT I agree to pay my Managed Care Copayment – HMO & PPO – at the time services is rendered. I understand the referral process of my Plan and agree to abide by the prescribed rules.

PLEASE INITIAL _____

MINOR CHILDREN I understand that my minor child should always be accompanied by an adult who may authorize care. Payment for services rendered to minor children is the responsibility of the adult accompanying the child and I agree to make provisions for payment at the time services is rendered.

PLEASE INITIAL _____

RELEASE OF INFORMATION Information regarding treatment of a minor may only be released after signature of the legal guardian(s). I hereby authorize the release of any information necessary to process insurance claims for services rendered by DURANT FAMILY MEDICINE CLINIC. I hereby authorize DURANT FAMILY MEDICINE CLINIC to release any and all medical information to previous and future physicians involved in my care. If you email our office with a medical question or information you are giving implied consent for information to be transmitted electronically. Our office must have written permission to release information regarding your care to any other person, including but not limited to a spouse, parent, sibling, etc. A valid HIPAA authorization to release protected health information is required prior to release

PLEASE INITIAL _____

WORKER'S COMPENSATION I hereby authorize DURANT FAMILY MEDICINE CLINIC to deliver written reports, records, xrays or other information pertaining to my medical diagnoses or treatments to my employer and/or any attorney(s) or their representative(s) that I employ or in the future may employ relating to my Worker's Compensation injury.

PLEASE INITIAL _____

FORMS There is a \$10 charge for each form completed by this office unrelated to your health insurance (ie disability, leave of absence, etc.) Forms and payment should be presented to the front office staff prior to your appointment. The Patient portion of the form must be completed and signed. A valid HIPAA authorization to release protected health information is required prior to release.

PLEASE INITIAL _____

I certify that the information given on the forms provided to me is correct and complete to the best of my knowledge and belief. Preceding information is agreed to by signature below

_____/_____/_____
DATE

SIGNATURE _____

Person responsible for payment; under 18, parent or guardian must sign

PRINT NAME _____

Durant Family Medicine Clinic

1600 W. University Blvd
Durant, OK 74701
Phone 580.924.5500
Fax 580.924.1991

PAYMENT POLICY

Thank you for choosing DFMC as your primary care provider. We are committed to providing you with quality and affordable health care. This is our payment policy, please read it, ask us any questions you may have and sign in the space provided below. A copy will be provided to you upon request.

PRIVATE PAY. Payment is expected at the time of your visit.

INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is required at each visit. **Knowing your insurance benefits is your responsibility, please contact your insurance company with any questions you may have regarding your coverage.** Non-covered services are those services you receive that may not be covered or not considered reasonable or necessary by your insurance. If your insurance changes, please notify us before your next visit so we can make the appropriate changes in our system.

CO-PAYMENTS/ COINSURANCE/ DEDUCTIBLES. All co-payments, co-insurance percentages, and/or non-covered service(s) and deductibles must be paid at the time of your visit. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, co-insurances and deductibles from patients may be considered fraud.

FRAUD & PROOF OF INSURANCE. If you fail to provide us with the correct insurance information and we are unable to verify insurance coverage, you will be required to pay in full at the time of your visit or reschedule your appointment. *You are committing FRAUD if you do not give us all your insurance coverage information.*

CLAIMS SUBMISSION. We submit claims to all insurance companies and will assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

NON-PAYMENT. If your account is over 90 days past due, you will receive notice stating that you have 20 days to pay your account in full. Failure to pay your bill may mean that you will be discharged from this clinic. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our clinic will only be able to treat you on an emergency basis.

MISSED APPOINTMENTS. All adult (21 yrs. old) patients who "no show" their appointment, without calling to cancel, may be charged \$25.00 per missed visit. Please call the front office to cancel visit 24 hours prior to your appointment.

Durant Family Medicine Clinic's prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

PATIENTS NAME, PRINTED

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY IF MINOR

DATE

DURANT FAMILY MEDICINE CLINIC
MEDICAL HOME AGREEMENT
FOR ACCOUNT _____

**This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER,
to focus on meeting ALL of your Healthcare Needs.**

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with **ongoing, quality** and **safe** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed **medically** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed **medically** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your PCP, to meet **all** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report **any** changes related to your health, treatments, medications, etc.
This includes use of all medications-prescription, over-the-counter, herbal and street drugs.
This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us **before** going to the Emergency Room, unless it is life threatening.
5. Notify us **after** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including **follow-up** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call **before** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER

Patient or Guardian Signature

Date

DFMC Staff Signature

Date

Durant Family Medicine Clinic

1600 W University Blvd Durant OK 74701

Phone 580.924.5500 Fax 580.924.1991

MEDICATION CONTRACT

All medications prescribed by a Durant Family Medicine Clinic physician after the date of this contract are included herein and made a part of this Medication Contract.

1. I acknowledge and consent to treatment with non-narcotic, narcotic, opioid or controlled substances. I understand that these medications were prescribed to me because I state that I have a serious condition. I am aware of risks associated with these meds that may include drowsiness, constipation, slowing of reflexes. I know that I should not drive or participate in any activity requiring mental alertness or physical coordination when I take narcotic, opioid or controlled substance medication(s). Further, I know that the use of these medications can lead to tolerance, physical dependence or addiction.
2. I agree to take my medication(s) as prescribed and directed by my DFMC physician.
3. I acknowledge and understand that I will need regular appointments to continue this treatment. Prescriptions will only be refilled at the time of the appointment and never over the phone. I will call the office for an appointment one (1) week before I run out of my medication.
4. I acknowledge and understand that I cannot obtain these or similar medications from a source other than Durant Family Medicine Clinic. I acknowledge and understand that doing this will result in no further similar prescriptions given for this problem from Durant Family Medicine Clinic.
5. I acknowledge and understand that Durant Family Medicine Clinic will not refill medications that have been lost, stolen, misplaced or damaged.
6. I agree not to share, give or sell my medication to any other person and I am aware that this constitutes a criminal act.
7. I acknowledge and understand that I cannot use alcohol or any street drugs with my medication.
8. I acknowledge and understand that if I am receiving medication or am the parent of a child receiving medication, I agree to random drug screening at any time at my own expense, including today. If I am called for a random drug test I agree to present to the office within 3 hours for drug screening. Failure to appear and provide valid urine for testing will be considered a violation of this contract. I understand that if I fail to show up for a medical management appointment it is grounds for termination from DFMC.
9. I agree to release this contract information to Alliance Health Durant Hospital and to pharmacies in Bryan and surrounding counties.
10. I consent to all pharmacies communicating with Durant Family Medicine Clinic with regard to my use of controlled and non-controlled substances and the providers of those substances.
11. I understand that a state and/or nationwide database will be accessed to find all medications I have been prescribed by all medical providers.
12. I understand that I must request a refill for all non-narcotic routine medications five (5) days before I will be out of the medication by calling my pharmacy. Routine medications for chronic disease(s) require an office visit every 3-6 months and may not be refilled if I do not see my physician on a routine basis.
13. I acknowledge and understand that violation of this contract is grounds for termination from Durant Family Medicine Clinic.
14. If I violate any tenet of this contract, I acknowledge and understand that this contract is broken and my medication will no longer be prescribed.

Print Name of Patient _____

Signature of Patient or Parent/Legal Guardian if under 18

_____/_____/_____
Date

PRESCRIPTION NOTICE

Prescriptions written at the time of your office visit are sent to your pharmacy **within 24** hours.

Telephone requests for medications are processed **within 72** hours.
Please plan accordingly.

You will receive a text message from our clinic when your prescriptions have been successfully faxed to your pharmacy.

If one or more of your prescriptions is a Controlled Substance, ie Narcotics, ADHD/ADD, Antidepressants, etc you may receive a text from two doctors clinic to ensure your medications have been sent.

If you have not received a text message **within the above time frame** please call 580.924.5500 and leave a message with our nursing staff.