Healing Companion Medical Clinic
New Patient Registration

PATIENT INFORMATION: (Please print)

Last Name _____ First Name _____ Sex M F

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Social Security _____ Marital Status _____

How were you referred to our office? _____

EMPLOYMENT INFORMATION:

Name of Employer _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone Number _____ Extension _____

INSURANCE INFORMATION:

Name of Insurance Company _____

Claim Address _____

City _____ State _____ Zip _____

Insurance Phone # _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder SS # _____ Policy Holder's DOB _____

Policy ID # _____ Group # _____

Policy Holder Employer _____ Phone # _____

SECONDARY INSURANCE INFORMATION:

Dr. Nhu Q. Tran, Board Certified in Internal Medicine
3110 Lamesa Garland, TX 75041-4201
Phone (972)675-3818 Fax (214)703-0808

Name of Insurance Company _____

Claim Address _____

City _____ State _____ Zip _____

Insurance Phone Number _____

Name of Policy Holder _____ Relationship to Patient _____

Policy Holder SS # _____ Policy Holder's DOB _____

Policy ID # _____ Group # _____

Policy Holder Employer _____ Phone # _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductable amount, coinsurance, or any other balance not paid by your insurance company.**

In order to control the cost of billing, we request that your co-payment, co-insurance, deductable or any other expected balance not covered by your insurance be paid at the conclusion of each visit. If the balance is unknown, it must be paid upon received when it is firstly mailed out to you. There will be an additional charge once your balance is mailed out after the first time. Your balance will be forwarded to a medical collection agency after 90 days.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection to the extent necessary. To determine liability for payment and to obtain reimbursement I authorize disclosure of portions of the patient records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, Private Insurance, and other health plans to Healing Companion Medical Clinic. This assignment will remain in effect until evoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.**

Signed _____ Date _____

Printed Name _____

Dr. Nhu Q. Tran, Board Certified in Internal Medicine
3110 Lamesa Garland, TX 75041-4201
Phone (972)675-3818 Fax (214)703-0808

PATIENT'S EMERGENCY CONTACTS AND INFORMATION:

Nearest Relative Name: _____ Address: _____ _____ City: _____State: _____ Zip Code: _____ Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Relationship to Patient: _____	Emergency Contact and Address: _____ _____ _____ City: _____State: _____ Zip Code: _____ Home Phone: ( ) Work Phone: ( ) Cell Phone: ( ) Relationship to Patient: _____

Do you have a durable power of an attorney for healthcare? Yes No

If yes, please provide the name: _____

Home phone: ( ) Cell phone: ( )

Do you have a legal guardian? Yes No

Would you like to be an organ donor? Yes No

RELEASE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT FOR PRIVACY NOTICE

I , _____, acknowledge that I have received a copy of the Privacy Notice. This is describes how my doctor may use and disclose my protected information. It also describes restrictions on the use and disclosure of healthcare information and the patient's rights. In addition, I only allow Dr. Tran or The Healing Companion Medical Clinic, to release or discuss my health information to the following individuals (family relatives or friends):

	Name	***Relationship***	***Phone number***
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____

Sign: _____ Date: _____

Dr. Nhu Q. Tran, Board Certified in Internal Medicine
3110 Lamesa Garland, TX 75041-4201
Phone (972)675-3818 Fax (214)703-0808

HEALING COMPANION MEDICAL CLINIC, PLLC

3671 Broadway Blvd Ste 500

Garland, TX 75043

Phone (972)675-3818

CONSENT FOR TREATMENT AND RIGHT TO REFUSAL TO TREATMENT

GENERAL CONSENT FOR TREATMENT: By signing below, I, _____, authorize Dr. Nhu Tran/Healing Companion Medical Clinic and her staff to conduct any diagnostic examinations, tests, and procedures, and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health, and to assess, diagnose, and treat my illness or injuries. I understand that it is the responsibility of my individual treating health care providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

Patient's signature: _____

Date and time: _____

Nhu Tran, DO
HEALING COMPANION MEDICAL CLINIC, PLLC
3671 Broadway Blvd, Ste 500
Garland, TX 75043
Phone (972)675-3818
Fax (214)703-0808

CONSENT FOR OBTAINING EXTERNAL PRESCRIPTIONS

I, _____, whose signature appears below, authorize Healing Companion Medical Clinic and its physician to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Patient's signature Date

_____ _____

Witness's signature Date

Patient Preferences Regarding Communication of Patient Health Information

My preferred method of communication regarding my **medical conditions** is indicated below (please check **only one**):

☐ Home Phone ☐ Work Phone ☐ Cell Phone

☐ Mailed Letter ☐ Guardian

If the above of communication is by phone, please check the appropriate box below (please check **only one**):

☐ Leave a message with detailed information.

☐ Leave a message with a call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like for us to call you at a different phone number for a particular test result or if you do not want to be called at all.

_____

Patient Name (please print)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

HEALING COMPANION MEDICAL CLINIC
PATIENT CONSENT AGREEMENT FOR CHRONIC CARE MANAGEMENT

Medicare now offers a new benefit for patients with multiple chronic diseases, and by consenting to this Agreement, you designate your provider, Dr. Nhu Tran, to provide chronic care management (CCM) services per the new rule.

Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don't have more than one chronic condition.

Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Provider Chronic Care Services

As part of this new benefit, your Provider agrees to make available the following services:
1. 24/7 access to a healthcare provider to address your acute, chronic care needs
2. Use of certified EHR software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversight
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Consent Terms

By signing this Agreement, you agree to the following terms required by Medicare:
1. You consent to your Provider providing CCM services to you.
2. You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
3. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
4. You understand that the Medicare Co-Insurance amount applies to CCM Services
5. You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Beneficiary or Caregiver

Signature: _____ Date: _____

Print Name: _____

HEALING COMPANION MEDICAL CLINIC, PLLC
Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing or audio equipment and/or devices that enable health care providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit, starting the date of 3/23/2020.
- I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    - If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    - I may revoke my right at any time by contacting Healing Companion Medical Clinic at 972-675-3818.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    - I understand that my insurance carrier will have access to my medical records for quality review/audit.
    - I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    - I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

- I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand.

and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____

Patient/Parent/Guardian's signature and date

_____

Printed Name of Patient/Parent/Guardian and date

_____

Witness Signature and date

HEALING COMPANION MEDICAL CLINIC'S POLICY

Revised 5/23/16

It is our goal to provide you, the patient, with the highest and most efficient level of health services available. Your assistance is necessary and plays an integral part in helping us obtain that goal as well as preserving the quality of care that other patients deserve.

1) Please give us a 24-hour notice prior to your appointment IF you are unable to keep your appointment and want to reschedule your appointment. You will be charged **$40.00** fee for the first time, **$60.00** for the 2nd time and **$85.00** after if you cancel your appointment less than 24 hours or do not show up for your appointment with Dr. Nhu Tran unless you have an unexpected and reasonable emergency.

2) If you are **more than 15 minutes late for your appointment**, Healing Companion Medical Clinic has the right to cancel your appointment and policy #1 will be applied regarding to the fee.

3) You are aware that you would lose your privilege of being a patient of Healing Companion Medical Clinic if you miss three (3) appointments without any reasonable explanation.

4) In term of medication refill, please call your pharmacy to fax the refill form or send electronic prescription refill over to us and it will be taken care within 24 to 48 hours from Monday to Friday. If you want to pick up a prescription, please kindly call us at least 24 to 48 hours in advance before you pick it up.

5) If you are sick and would like the doctor to see you as soon as possible, please call us ahead of time to schedule the appointment. We will do our best to fit you in the earliest opening schedule that we have. Please DO NOT show up without calling and expect to be seen in the clinic right away.

6) For private insurance patients and patients who have only Medicare as their insurances, **please pay your co-pay and/or co-insurance BEFORE seeing the doctor**. Your service will be REJECTED if you do not pay your co-pay and/or co-insurance or any remaining balances.

7) Your first balance statement is complimentary. There is **$5 fee** for any balance statement after.

8) Once you receive a balance statement from our office , please submit your payment as soon as possible. **20% late fee** will be processed after **30 days** the first balance statement mailed out to you. If you cannot make your payment upon received, please kindly call our office immediately and make arrangement for your payments. If you do not pay in full within **three (3) months or within the arrangement period, 30% late fee** will be added monthly and you

Dr. Nhu Q. Tran, Board Certified in Internal Medicine
3110 Lamesa Garland, TX 75041-4201
Phone (972)675-3818 Fax (214)703-0808

will lose the privilege of being a patient of this clinic and your due amount will be sent to a **professional medical collection agency**.

9) If we receive a bounced check from you, you will be charged **$50.00** fee for bounced check plus the amount on the check. You will be reported to the District Attorney Office if you refuse to pay the requested amount after thirty (30) days since the bounced check was given.

10) You will be charged **$20 fee per medical form** in addition to office visit charge if the doctor has to fill out medical forms such as forms for school, sport, or camp; forms for life insurance and legal uses such as Family and Medical Leave Act; disability forms....etc...

11) Our regular office hours are from **Monday to Thursday from 7 am to 3 pm and Friday from 7am to 5pm**. ***We are closed on Saturday and Sunday***. If it is a medical emergency after-hours, please call 911 or go to the nearest emergency room. We appreciate if you can call our office DURING BUSINESS HOURS (not after-hours) to cancel or reschedule your appointments. Phone calls after-hours are only for true medical emergency as you can leave a message on our voicemail and the doctor will be notified shortly to call you back.

12) Your right to protected health information, known as HIPPA, is listed on our website at www.healingcompanion.com for you to review. Don't hesitate to ask us if you have any question.

_____, have read the above and agree to be compliant.

Patient Signature: _____ Date: _____

Dr. Nhu Q. Tran, Board Certified in Internal Medicine
3110 Lamesa Garland, TX 75041-4201
Phone (972)675-3818 Fax (214)703-0808