Mt. Pleasant Family Practice

Chris Burling, M.D.
Beverley J. Springstead, MPAS, PA-C
618 N. Jefferson, Suite 1
Mt. Pleasant, TX 75455

(903)575-9500
FAX (903)575-9866
www.mpfp.net

PATIENT INFORMATION

Name____Date of Birth__________________
Last First Middle

Address_______________________City_____________________State_____Zip Code__________

Primary phone#_______________ ☐Home ☐Cell ☐Work Secondary phone#_________________ ☐Home ☐Cell ☐Work

Email __________________________________ Sex ☐ M ☐ F Social Security#____________________

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Minor

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other_________

Employer/School___________________________________Occupation/Grade Level__________________

Employer/School Address____________________________________ Phone# _____________________

Emergency Contact _________________________Relation______________ Phone#_________________

GUARANTOR/INSURANCE INFORMATION

Person responsible for account__________________________________Relation to Patient______________

Date of Birth______________Social Security#________________Phone# ___________________________

Address*(if different)* ______________________City_________________State_______Zip Code_________

Employed by___________________________________Occupation_____________________________

Employer Address___________________________________ Employer Phone#______________________

Insurance company_________________________**ID#**____________________**Group#**______________

Names of others covered under this plan____

Is patient covered by additional insurance? ☐ Yes ☐ No

If yes, list name of insurance company ____________________

ID#______________________ Group#______________ Subscriber's name________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with the above listed insurance company(ies) and assign directly to Christopher Burling,MD/Beverley Springstead,MPAS,PA-C all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named providers may use my health care information and may disclose such information to the able named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end upon written request.

____ Date _____________________
Signature of Patient/Parent/Guardian/Personal Representative

____ __________________________
Please ***Print*** Name of Patient/Parent/Guardian/Personal Representative Relation to Patient

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Name ____DOB ____________________

ALLERGY INFORMATION

Are you allergic to any medications? *Yes No*

If yes, please list and describe your reaction to the medication.

Medications:	Reactions:
____________________	____________________
____________________	____________________
____________________	____________________

CURRENT MEDICATIONS

Do you regularly take prescription or non-prescription medications? *Yes No*

If yes, please list the medications and dosages below.

Medications:	Dosages:
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

PAST MEDICAL HISTORY

Do you have or have you had any of the following problems?

Condition/Disease/Diagnosis	YES	NO
Acid Reflux, Heart Burn, GERD		
ADD/ADHD *(circle one)*		
Allergies		
Alzheimer's		
Anxiety		
Anemia-Iron Deficient/Pernicious/Sickle Cell *(circle one)*		
Arthritis, Osteo/Rheumatoid/Psoriatic *(circle one)*		
Asthma		
Bipolar Disorder		
CAD-Coronary Artery Disease		
Cancer-Please List Type:		
CHF-Congestive Heart Failure		
COPD/Emphysema		
Depression		
Diabetes: Insulin Dependent or Non-Insulin Dependent *(circle one)*		
Eczema		
Epilepsy		
Glaucoma		
Headaches		
Heart Attack		
High Blood Pressure (HTN)		
High Cholesterol		
Immunodeficiency		
Kidney Disease		
Liver Disease		
Mental Illness-List Type:		
Migraines		
Multiple Sclerosis		
Obesity		
Obsessive Compulsive Disorder (OCD)		
Otitis Media-Chronic		
Parkinson's Disease		
Prostate Disease		
Psoriasis		
Seizures		
Sinusitis-Chronic		
Spinal Injury		
Stroke (TIA)		
Thyroid Disease		

PAST SURGICAL/PROCEDURE HISTORY

Have you had any surgeries/procedures in your life? *Yes No*

If yes, please list surgeries/procedures & dates below.

____

____

____

OB/GYN HISTORY

females only

Date of:

last menstrual period ______________last PAP smear_________________last mammogram______________

# of pregnancies _______# of vaginal deliveries ________# of C-sections _________

FAMILY HISTORY

Have any of your family members, living or deceased, ever been diagnosed with the following? Please check family member.

	Father	Mother	Brother	Sister	Son	Daughter	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
High Blood Pressure										
Diabetes										
High Cholesterol										
Heart Disease										
Stroke or TIA										
Heart Attack										
Thyroid Disease										
Breast Cancer										
Colon Cancer										
Lung Cancer										
Ovarian Cancer										
Other Cancer										
Osteoporosis										
COPD/Emphysema										
Asthma										
Osteoarthritis										
Rheumatoid Arthritis										
Anxiety										
Depression										

SOCIAL HISTORY

Are you currently employed? *Yes No* If *yes*, where?___________________________________

Present or past job title ___________________________________

What is your marital status? *(please circle one) married single divorced separated widowed*

Do you have any children? *Yes No*

If *yes*, how many? ________ Girls _______ Boys

Have you ever smoked? *Yes No*

If *yes*, how many packs per day? ________How many years have you been smoking? _______

Do you still smoke? *Yes No*

If *no*, when did you quit? ____________How many packs a day did you smoke? ________

Have you ever used smokeless tobacco? *Yes No*

If *yes*, what type? ____

Do you still use smokeless tobacco? *Yes No*

If *yes*, how much a day? ________

How many years have you been using smokeless tobacco? _________________

If *no*, when did you quit? ___________ How much did use a day? _________________

Do you drink alcohol? *Yes No*

If *yes*, how often? *(please circle one) rare social regular*

How many drinks per week? _____________

Do you use illegal drugs? *Yes No* Have you in the past? *Yes No*

If *yes*, please list what type? ____

ADVANCE DIRECTIVE

An **advance directive** *tells your doctor what kind of care you would like to have if you become unable to make medical decisions. If you are 18 years old or older:*

Do you have an **Advance Directive** in place? *Yes No*

If *no*, do you wish to discuss this with your healthcare provider today? *Yes No*

PREVIOUS PHYSICIAN INFORMATION

Please list the names & addresses of your most recent physicians.

Name:	Address:
____________________	____________________
____________________	____________________
____________________	____________________

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Miscellaneous Policies

1. **PCP**- Dr. Burling MUST be listed, online, as you Primary Care Physician *PRIOR* to your appointment. If Dr. Burling is not listed as your PCP, your appointment will be canceled. Our office will attempt to notify you if we find another physician listed, however, this is ultimately your responsibility in maintaining. (Please understand that while Dr. Burling is listed as your PCP, one of our Physician's Assistants, under the supervision of Dr. Burling, may be the one treating you).

2. **Referrals**- Based upon insurance requirements, our office must have accurate documentation for all referrals. This may require you to be seen by one of our physicians before the referral process can begin. Due to the extensive nature of the referral process, we ask that you allow our office at least 5-7 business days for any referrals to be completed. You will be notified of your appointment as soon as this process has been completed.

3. **Prior authorizations**- Prior authorizations will be performed in a timely fashion by our office. If any updates are needed on prior authorizations please contact your insurance company; as they are solely responsible in approving these. Our office will not be responsible for handling any prior authorizations ordered by other physicians.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our **Miscellaneous Policies**. Please let us know if you have any questions or concerns.

I have read and understand these Miscellaneous Policies and agree to abide by its guidelines:

____________________________________ ______________________

Signature of patient or responsible party **Date**

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____
Signature of Patient or Personal Representative

____
Date

____
Name of Patient or Personal Representative

____
Description of Personal Representative's Authority

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PHYSICIAN ASSISTANT PATIENT EDUCATION FORM

What is a Physician Assistant (PA)? A physician assistant is a graduate of an accredited PA program who is academically and clinically trained to practice medicine with the supervision of a licensed physician. ***Physician Assistants are trained as dependent health care professionals and work as part of the Physician-Physician Assistant team in the delivery of quality health care.***

What are PAs legally allowed to do? In Texas, all states, U.S Federal Government and Uniformed Services, the District of Columbia, and the territory of Guam, physicians may delegate to PAs those medical duties that are within the physician's scope of practice, the PAs training and experience, and are allowed by law. As part of their comprehensive responsibility PAs perform physical examinations, diagnose and treat illnesses, provide preventive medicine counseling and patient education, order and interpret lab tests, suture wounds, assist in surgery, and make rounds in nursing homes and hospitals, and write prescriptions.

What's the difference between a PA and a physician? Physician assistants are educated in the medical model; in some schools they attend many of the same classes as medical students. One of the main differences between PA education and physician education is not the core content of the curriculum, but the amount of time spent in formal education. In addition to time in school, physicians are required to do an internship, and the majority also complete a residency in a specialty following that. PAs do not have to undertake an internship or residency. In general, a physician assistant will see many of the same types of patients as the physician. The cases handled by physicians are generally the more complicated medical cases or those cases which require care that is not a routine part of the PA's scope of work. A physician has complete responsibility for the care of the patient. PAs share that responsibility with the supervising physicians.

Do PAs have to pass a national board certifying examination? In the 50 states with laws covering PA services (including Texas), PAs are required to pass a national certifying board examination developed by the National Board of Medical Examiners and administered by the independent National Commission on Certification of Physician Assistants. PAs are licensed or registered by the state in which they practice. To maintain board certification the PA must obtain at least 100 continuing medical education hours every two years and retake the board examination every six years.

____________________________________ ____________________________________

PATIENT SIGNATURE DATE

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Information regarding patient for whom authorization is made:

Name____DOB___________________________

Address:___________________________City:______________________State:_______ Zip code:___________

Phone: ____________________________

Information regarding health care provider or health care entity authorized to disclose this information:

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Information regarding person or entity who can receive and use this information:

Name: ____

Relation:______________________________

Address:___________________________City:______________________State:_______ Zip code:___________

Phone: ___________________________

Specific information to be disclosed:

□ Medical Record from (insert date) __________________ to (insert date) __________________

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: ____

Include: *(indicate by initialing)*

________ Drug, Alcohol or Substance Abuse Records

________ Mental Health Records (Except Psychotherapy Notes)

________ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

Reason for release of information: *(choose all that apply)*

□ Treatment/Continuing Medical Care

□ Personal Use

□ Billing or Claims

□ Insurance

□ Legal Purposes

□ Disability Determination

□ School

□ Employment

□ Other *(Specify)*: ____

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _______Day: _______ Year: ________.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv)**Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:

Patient/Legal Representative: ____ Date:_______________

If Legal Representative, relationship to Patient: ____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): _____________________________________ Date:________________

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Patient Portal Consent Form

Access to this secure patient portal is an optional service. It may suspend or terminate at any time and for any reason. I understand that my access to this portal will not affect the current level of care I'm already receiving from Mt. Pleasant Family Practice. I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the patient portal and agree that I understand the risks associated with online communications herein. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Mt. Pleasant Family Practice should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I understand that this agreement will remain in effect for 12 months. At the end of that time, I will be asked to renew my confidential email and patient portal login. It is my responsibility to notify Mt. Pleasant Family Practice if there is a change in my email account or if I feel that my secure password has been breached. I agree not to hold Mt. Pleasant Family Practice or any of its staff liable for network infractions beyond its control.

Upon signing this document, your signature on this form is your agreement to the Policy and Procedures for our patient portal.

please print all information clearly

Full Name ________________________________ Date of Birth _______________

Confidential e-mail address ____

Signature ____ Date _____________

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please print all information clearly

Full Name ____ Date of Birth ___________________

Confidential e-mail address ____

Signature ____ Date _________________