DR. FERGUS AKWAR
3317 Altamesa Blvd.
Fort Worth, TX 76133
(Please Print)

SECTION I: PATIENT INFORMATION DATE: _____

Name: _____

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

Home Phone(___) _____ Work Phone(___) _____ Cell Phone(___) _____

SSN# _____ DOB ___/___/_____

The best time to contact me is:_____ ____A.M. _____ P.M. on my ____ Home phone ____Work phone____Cell phone

Check whichever applies: ___ Minor ___ Single ___Married ___ Widowed ___ Separated ___ Divorced

Spouses or Parent's Name:_____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Relationship _____ Phone_____

Email Address:_____

SECTION II RESPONSIBLE PARTY

Relationship to Patient: _____ Self _____ Spouse _____ Parent ____ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone (___) _____

Employer: _____ Work Phone (___) _____ SSN# _____

SECTION III INSURANCE INFORMATION

Name of Insured: _____ DOB _____ Relationship to Patient _____

SSN# _____ Name of Employer _____ Work Phone (___)_____

Address of Employer: _____ City _____ State: _____ Zip: _____

Insurance Company _____ Member ID #_____ Grp #_____

Ins Co Address: _____ Ins Co. Phone: _____

********** DO YOU HAVE ADDITIONAL INSURANCE: _____ Yes _____ No If yes, complete the following **********

Name of Insured _____ DOB _____ Relationship to patient _____

SSN#: _____ Name of Employer: _____ Work Phone(___) _____

Address of Employer: _____ City _____ State _____ Zip _____

Insurance Company _____ Member ID #_____ Grp # _____

Ins Co Address: _____ Ins Co. Phone (___) _____

AUTHORIZTION TO RELEASE AND ASSIGN BENEFITS. I hereby assign, transfer and set over to Rapha Medical Clinic all of my rights, title, and interest to any medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. I understand that I am financially responsible for all charges whether they are covered by my insurance. CONSENT TO TREAT: I hereby give consent to treat my medical condition and obtain medic al information from other sources that me be pertinent to the continuation of my care.

Sign: _____ Date: _____

RAPHA MEDICAL CLINIC

AUTHORIZATION and CONSENT TO TREAT

Medical & Surgical Consent: I, the undersigned, consent to and authorize any examination or medical treatment, and/or services rendered to the patient by the physician/provider or his/her associate which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

Accidental Exposure of the Healthcare worker: I understood that Texas law provides that if any healthcare worker is exposed to a patient's blood or other body fluid, Rapha Medical Clinic may perform tests on the patient's blood or other body fluid to determine the presence of Human Immunodeficiency Virus (which is the causative agent of AIDS). I give my consent for the testing of other communicable disease, including but not limited to Hepatitis and Syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient.

The undersigned certifies that he/she has read and accepts this authorization form and is the patient or the parent of the patient or legally authorized representative of the patient.

_____

Patient Name (Patient Print)

_____

Signature of Patient or Patient's Legally Authorized Representative
Firma

_____ _____

Relationship
Hombre Parentesco

Date
Fecha

Rapha Medical Clinic
Financial Policy

We are happy that you have chosen us as your primary healthcare provider. As a partner in our relationship, it is important that you understand and agree on our financial policy.

We must first understand that our relationship is with you as our patient. **Your insurance is a contract between you and your insurance company and possibly your employer. You are responsible to understand your policy and its terms including referrals and pre-certifications necessary prior to your visit.**

It is your responsibility to provide us with your most current billing information to include: Insurance I.D. Card, address, all available phone numbers, and contact information. These must be updated at each visit.

Before we can provide services, we must first verify that we are participating providers with your insurance company. If we are participating provider with your insurance, it is possible that not all services provided are covered by your insurance, if so; you are responsible for payment of these services.

If we are not providers for your insurance company, FULL PAYMENT is due prior to service. We will file your claim provided we are paid in full at time of service.

All Co-Pays and Deductibles are due at time of service. These are **Estimates** provided by your insurance company. You are responsible to pay any differences in ht estimate and what is **actually paid** by your insurance as these numbers are often different.

We will send you a statement on a monthly basis of balances due. **These must be paid in full within 30 days. If you have an overdue balance we will not schedule a new appointment until all balances are paid in full.**

Balances may be paid by cash OR credit card (Visa, Mastercard)

If your overdue account is sent to a collection agency, full payment of prior charges will be required in order for you to make an appointment.

Full payment is due at time of service. I have read and understand this Financial Policy.

_____ _____

Signature of Responsible party **Date**

Patient Name: _____ **Patient Date of Birth:** _____

RAPHA MEDICAL CLINIC
DR. FERGUS AKWAR
3317 ALTA MESA BLVD
FORT WORTH, TX. 76133

Acknowledgement of Receipt of Notice of Privacy Practices

I. I have been informed and received a copy of the *Notice of Privacy Practices for Rapha Medical Clinic.* Rapha Medical Clinic reserves the right to modify the privacy practice outlines in the notice.

II. I authorize Rapha Medical Clinic staff to leave telephone messages regarding my appointments, test/results, and general care at the following designated telephone numbers in the event that I am unavailable to personally take the call. I reserve the right to change this information at any time.

Telephone Numbers:_____ _____
Telephone Numbers:_____ _____

III. Disclosure of Information to Relatives or Other Designated Persons

The following individuals are people that I would like to be involved in or have access to my protected health information on a routine basis. I authorized for Rapha Medical clinic to share my protected health information with:

Name	Relationship	Phone#
Name	Relationship	Phone#
Name	Relationship	Phone#

Patient Name:_____ Date of Birth: ___/___/_____

Social Security #:_____

_____ _____
Patient Signature or Patient Representative Signature Date

_____
Relationship to Patient (required if patient is a minor or an adult who is unable to sign this form.)

RAPHA
MEDICAL CLINIC
3317Altamesa Blvd. Fort Worth, TX 76133
Tel (817)-292-2011 Fax (817)292-3691

NO SHOW FEE POLICY

Each time a patient misses an appointment without proper notice, another patient is prevented from receiving care. We reserve the right to charge for the occurrences.

There will be a fee of **$10** applied to your account **if you fail to notify** the office of a cancellation within **24 hours** prior to the schedule appointment time.

However, our office will make an attempt to contact and remind you of your appointment the day before.

By signing below you acknowledge that you have read and understood this notice.

_____ Print Name

_____ Signature

_____ Date

PAIN SCREENING

Date _____

Patient Name: _____ Sex: M F

Telephone Number: _____ Age: _____

1. Are you in pain?

   No pain = 0 If yes continue

2. Is pain tolerable?

   Yes = continue to question 3

   No = continue to question 4

3. Does it prevent you from doing activities?

   No = 1 (pain tolerable)

   Yes = 2 (pain tolerable)

4. Can you use the telephone, watch television or read?

   Yes = 3 (pain tolerable)

   No = 4

5. Pain is intolerable and can't use phone, watch television or read.

   Yes = 4

Rapha Medical Clinic

Name:_____ Date:_____

D.O.B:_____

(Please Print)

Medications	Dosage (mg)	Frequency

Write on back of from if more room is needed for medications

Are you allergic to IV dye or X-Ray contrast? Yes or No

Allergies to:

Medications	Food
_____	_____
_____	_____

Have you had recent Lab work? Yes No Where?_____

Rapha Medical 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 this notice carefully.

Please note that we will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

Medical Record: We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements.

For Treatment: We may use medical information about you to provide you with medical treatment of services. We may disclose medical information about you to doctors, nurses, technicians, medical students and other people who are taking care of you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information.

For Healthcare Operations: We may use and disclose your medical information for our health care operation. This might include measuring and improving quality, evaluation the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credential we need to serve you.

Public Use: We may use and disclose your medical information when federal, state or local law requires us to do so.

Changes: We have the right to make changes in our privacy practice and the new terms of our notice will be effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practice we will change this notice and make the new notice available upon request.

Complaints/Comments: If you have a comment or complaint regarding our Privacy Policy or if you believe your privacy rights have been violated you should contact:

Privacy Officer
Rapha Medical Clinic
3317 Alta Mesa Blvd
Ft. Worth, TX, 76133

OR

Secretary of the Dept. of Health/Human Svcs
200 Independence Ave., SW Room 509 HHS Bldg.
Washington, D.C. 20201