ATHENA FAMILY MEDICINE

PATIENT REGISTRATION

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:
Preferred Method of Contact for reminder calls and other electronically generated messages: (Please Select Only One Option) ☐ Voice ☐ Text			If Voice, Please Select Preferred Number : ☐ Home ☐ Cell ☐ Work
Date of Birth:	Sex: ☐ Male ☐ Female		Family Physician or Pediatrician:
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:			Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:		Relationship to Patient:

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Sign Language ☐ Spanish	☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Other
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I have read and agree to Athena Family Medicine's (AFM) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to AFM all money to which I am entitled for medical expenses related to the services performed from time to time by AFM, but not to exceed my indebtedness to AFM. I authorize AFM to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be mad to AFM. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.
If you do not wish to share your healthcare information with other medical providers you can contact AFM at 469-931-2602 or www.AthenaFamilyMedicine.com

I have reviewed a copy of Primary Health Medical Group's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:**

Printed Name of Responsible Party: X _____ **Date:**

8301 Lakeview Pkwy, Suite 106, *Rowlett, TX 75088
469-931-2602 www.AthenaFamilyMedicine.com

Name:

ATHENA FAMILY MEDICINE

Date:

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: _____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ NONE

(If yes, to what & what reaction?) _____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Result, if known _____

Sigmoidoscopy or Colonoscopy (circle one) Date (year)_____ Abnormal? □ No □ Yes
Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where _____ Abnormal? □ No □ Yes

please go to next page

PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

Condition	*Now*	*Past*	*Comments*
Alcohol / Drug abuse	☐	☐	
Allergy (Hay Fever)	☐	☐	
Anemia	☐	☐	
Anxiety	☐	☐	
Arthritis (Rheumatoid)	☐	☐	
Arthritis (Osteoarthritis)	☐	☐	
Asthma	☐	☐	
Bladder / Kidney Problems	☐	☐	
Blood Clot (leg)	☐	☐	
Blood Clot (lung)	☐	☐	
Blood Transfusion	☐	☐	
Breast Lump (benign)	☐	☐	
Cancer Breast	☐	☐	
Cancer Colon	☐	☐	
Cancer Other Type	☐	☐	
Cancer Ovarian	☐	☐	
Cancer Prostate	☐	☐	
Cataracts	☐	☐	
Chicken Pox	☐	☐	
Colon Polyp	☐	☐	
Coronary Artery Disease	☐	☐	
Depression	☐	☐	
Diabetes (adult onset)	☐	☐	
Diabetes (childhood onset)	☐	☐	
Diverticulosis	☐	☐	
Emphysema (COPD)	☐	☐	
Fractures (broken bones)	☐	☐	Where?
Gallbladder Disease	☐	☐	
Gastroesophageal Reflux (Heartburn/GERD)	☐	☐	
Glaucoma	☐	☐	
Gout	☐	☐	
Gynecological Conditions (Endometriosis)	☐	☐	
Gynecological Conditions (Fibroids)	☐	☐	
Gynecological Conditions (Other)	☐	☐	
Heart Attack	☐	☐	
Hepatitis – Type A	☐	☐	
Hepatitis – Type B	☐	☐	
Hepatitis – Type C	☐	☐	
Hepatitis – Other	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Hip Fracture	☐	☐	
Irritable Bowel Syndrome	☐	☐	
Kidney Disease / Failure	☐	☐	
Kidney Stones	☐	☐	
Liver Disease	☐	☐	
Migraine Headaches	☐	☐	
Osteoporosis	☐	☐	
Pneumonia	☐	☐	
Prostate (enlargement)	☐	☐	
Prostate (nodules)	☐	☐	
Seizure / Epilepsy	☐	☐	
Skin Condition (Eczema)	☐	☐	

please go to next page

Personal History continued

Condition	*Now*	*Past*	*Comments*
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other (list)			
Other (list)			

□ Check box if you have no history of significant medical illnesses.

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	*Code*	*Yes*	*Year*	*Comments*
Abdominal surgery				
Angiogram (heart)				
Angiogram (vascular)				
Appendectomy (appendix removal)				
Back surgery (lumbar)				
Biopsy (location in comments)				
Breast Biopsy				Circle: Right Left Both
Breast surgery				Circle: Right Left Both
Cataract surgery				
Colonoscopy				
Coronary Bypass				
Coronary Stent				
C-Section				
Echocardiogram (heart)				
EGD (Stomach Endoscopy)				
Gallbladder Removal				Circle: Laparoscopic (.)
Heart Surgery (other than coronary bypass checked above)				
Hip Surgery				Circle: Right Left Both
Hysterectomy (partial, ovaries left)				Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (total, including ovaries)				Circle: Laparoscopic Vaginal Abdominal
Knee Surgery				Circle: Right Left Both
LEEP (Cervix surgery)				
Neck (Spine) surgery				
Ovary Removal				Circle: Right Left Both
Pulmonary Function Test				
Sigmoidoscopy				
Sinus Surgery				
Stress Test (stress echo)				
Stress Test (thallium/perfusion)				
Stress Test (treadmill)				
Tonsillectomy				
Tubal ligation				
Vasectomy				
Other (list)				

□ Check box if you have never had any medical procedures or surgeries.

please go to next page

FAMILY HISTORY

Adopted? □ **No** □ **Yes.** If adopted and you do not know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Hyperlipidemia – high cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism / Drug abuse										
Alzheimers										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other type										
Colon Polyp										
Diabetes Type I (childhood onset)										
Emphysema (COPD)										
Genetic Disorder (explain)										
Glaucoma										
Heart Disease (CHF)										
Heart Disease (Other)										
Hepatitis B or C										
Hip Fracture										
Hypothyroidism / Thyroid Disease										
Kidney Disease										
Kidney Stones										
Macular Degeneration										
Stroke										
Sudden Cardiac Death										
Other (list)										
Other (list)										

please go to next page

HEALTH ISSUES:

Tobacco Use:

Smoke or smoked cigarettes/ pipe/ cigars (circle)?
□ Never □ Yes

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff or Chew

Quit date _____ Currently use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:

Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

How many times in a year have you had >3 drinks (for women) >4 drinks (for men) in a day? _____

Drug Use:

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

Please continue to next column on right

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future:
□ male □ female

Birth control method or STD prevention (check all that apply):
□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy □ Tubal ligation
□ Other method
(specify):_____

Other (ADL):

Military Service? □ No □ Yes
Blood Transfusion? □ No □ Yes
Exposure to toxic chemicals at work? □ No □ Yes
Exposure to toxic chemicals doing hobbies? □ No □ Yes

Diet:

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other _____

Exercise: Do you exercise regularly? □ Yes □ No

If yes, what kind of exercise? _____

_____

How long (minutes)? _____ How often? _____

Do you use a helmet for recreational activities?
(e.g. bike, skateboard, ski) □ Not applicable □ Yes □ No

Do you use seatbelts consistently? □ Yes □ No

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SAFETY:

Does your home have a working smoke detector? □ Yes □ No

Do you have guns in your home? □ No □ Yes

If yes, are they locked up & ammo stored separately? □ Yes □ No

Have you or any family members ever been hurt, insulted, threatened or screamed at? □ No □ Yes

SOCIAL DOCUMENTATION:

Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): _____

Country of birth: _____

Who lives at home with you: □ No one □ Spouse/partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, extended family, etc) _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

_____

_____

please go to next page

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker

□ other _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children: _____ Ages (if minors): _____ # of grandchildren: _____ # of great grandchildren: _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

Thank-you for taking the time to complete this form!

ATHENA FAMILY MEDICINE

KEVIN VO, M.D.
Board Certified Family Medicine

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
Obtain payment from designated third-party payers.
Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of your *Notice of Privacy Practices* of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient Name: _____
Printed Patient Name or Representative

Relationship to Patient
(If other than patient): _____

_____ _____
Patient's Signature **Date**

Witness: _____ _____
Signature Date

8301 Lakeview Pkwy, Suite 106, *Rowlett, TX 75088
www.AthenaFamilyMedicine.com
469-931-2602

ATHENA FAMILY MEDICINE

KEVIN VO, M.D.
Board Certified Family Medicine

CONSENT FOR TREATMENT

I, _____, authorize and direct the licensed practitioners and staff of Athena Family Medicine to render medical care as determined necessary at the time of service.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

If patient is a minor or unable to sign:

_____ _____
Name of Person Giving Consent Relationship to Patient

_____ _____
Witness Signature Date

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____, give the physicians and staff of Athena Family Medicine permission to discuss all aspects of my personal health history, condition, and treatment with my:

Spouse: _____ Other: _____

Parent: _____ Guardian: _____

No One: _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

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ATHENA FAMILY MEDICINE

KEVIN VO, M.D.

Board Certified Family Medicine

OFFICE POLICY

We would like to thank you for choosing **Athena Family Medicine** as your Primary Care Provider. We have written this policy to keep you informed of our current office policies.

Office Hours: Our clinic is open from Monday - Friday, 8:00 a.m. – 5:00 p.m.

After Hours Acute Care *"ATHENA TELEHEALTH":* Offered to our established patients for "Acute Illness," only. ***Please note, that we will not be prescribing pain medication or any refills on medications***

Ages: Our clinic treats patients ages two and above.

Appointments: We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness.

After Hours and Emergencies: For emergency, please call 911 right away.

Urgent Need or Sudden Illness: We have a limited number of same day or "work-in" appointments available every day. Please call early in the day, as these spots fill up quickly. If there are no available appointments with your physician, the Receptionist will offer an appointment with the physician assistant or transfer you to the Medical Assistant who will discuss your needs with a physician and determine what you should do.

Cancellations: Please call within 24 hours if you are unable to keep your scheduled appointment. This allows us to provide that time slot to another patient.

Running on time: We know your schedule is busy and that your time is valuable. Please let us know if you have waited more than 15 minutes so we can double check to see if you have been properly checked in. Remember that we are running several different schedules. If someone who arrived after you is called before you, they might be having blood drawn or seeing a different provider.

Treatment of Minors: Patients under the age of 18 must be accompanied by a responsible adult or have a written Permission for treatment, from a parent or guardian, along with copy of parent's driver's license. New Pediatric patient from, which has consent for treatment can be downloaded from our website, www.AthenaFamilyMedicine.com

Narcotics: We do not prescribe narcotics. Patients who are required the use of narcotics, will be referred to a Pain Management specialist for treatment.

Psychiatric Management: We routinely treat mild depression, anxiety, and insomnia. However, we do **not** treat Bipolar Disorder or ADD/ADHD. We also do **not** treat *Pediatric psychiatric disorders.* Patients will be referred to a Psychiatrist for treatment based on the severity of their condition. Patients taking psychiatric medications are required to be seen in our office **every three months** for assessment, medications refill, and will be required to get a urine drug test.

Weight Management / Obesity: Patients who required weight management from our physician must first undergo a complete physical exam, including EKG and blood work. Patients who are candidates for weight loss medical management are required to be seen at our clinic ***MONTHLY*** for assessment and medications refill.

OFFICE POLICY

Please be aware that most insurance may ***not*** cover for weight loss management office visit. We cannot change coding to fit needs of insurance coverage.

Testosterone Management: Patients who are candidates for Testosterone replacement therapy, must first undergo a complete physical exam, EKG, blood works, urine drug test, and sign a Controlled Substance Agreement Policy. Patients are required to be seen in our office **every three months** for assessment, medications refill, urine drug test, and Testosterone check. *Patient must receive injections by Athena Medical Staff in office with doctor present.*

Lab Work: Lab works are drawn in our office by our medical assistant and are sent out to a reference lab, Lab Corp. If you want your send-out lab work to be sent to a specific lab, please let us know.

Labs Ordered by Other Physicians: We **do not** routinely draw lab work which has been ordered by other physicians. However, we will fulfill this request if you are here for an appointment. If another physician wants blood tests, but cannot draw them in his/her office, please ask that physician for a form to take to the lab of your choice.

Lab Work Fees: A limited number of lab services will be billed by our office. All other services will be billed by the contracted lab. Please contact their billing department prior to calling our office. We do not have access to their billing information.

Physical Exams: We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. *However, insurance benefits vary.* Some policies cover "wellness" and others cover visits when you have a complaint. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.

Medicare Physical Exams: Refer to the Medicare letter which is available online or in our office.

Test Results: If you have diagnostic testing, i.e., labs, x-ray, Echo, ultrasound, sleep study, your doctor will review your results, typically 7-10 days. Your doctor will determine if you would need a follow up appointment based on the test findings. Our clinic will contact you if an appointment is needed.

Patients are encouraged to register with our Patient Online Portal to view patient's medical records, including test and lab results. Please visit our website at www.AthenaFamilyMedicine.com and register on our Patient Online Portal.

Prescriptions and Refills:
• The best time to get a prescription refill is at your appointment.
• We do not refill antibiotics. Patients who required antibiotics must be seen by our physician.
• If you need to call us for refills, please don't wait until you have run out. Most refills required the doctor's approval.
• Some medications have potential side effects that must be monitored. We require check-ups every 3 or 4 months for these medications. Be sure to keep your follow-up appointments.
• Please don't call after hours for prescription refills.

Samples: We sometimes offer samples to help you try out a new medication before you purchase it. Remember that samples are not a long term way to fill your prescription. We do not always have samples of your medications. Please do not rely on samples for medications you take long term.

Referrals: Sometimes this can be done on the same day as your appointment and sometimes it can take 2-3 days, depending on your insurance and/or the urgency of your situation.

OFFICE POLICY

Someone will contact you as soon as the referral authorization is obtained. Please understand that it can sometimes take a few weeks to get an appointment with a specialist depending on the specialist's appointment schedule.

Dismissal: If you are "dismissed" from the clinic, it means that you can no longer schedule appointments, get medication refills or consider us to be your doctor.

Common Reasons for Dismissal
• Recurrent failure to keep appointments, frequent no-shows
• Noncompliance, which means you don't follow physician instructions about an important health issue
• Abusive to staff and other patients
• Failure to pay your bill

Dismissal Process
We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, please make prior arrangements with our staff.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. Please note, it is also your responsibility to know your insurance benefits. We will need all your demographic and insurance information prior to your appointment. We will also request an update on this information approximately every six months thereafter. We ask that at the time of your appointment you bring your insurance card and a photo ID as well as any other forms that will assist in making sure that your claim is filed correctly.

Fees / Co-Pays: At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our clinic, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due.

Auto Accident: We ***do not*** see automobile related injury visits.

Worker's Compensation: If your injury is due to an accident at your work place, please inform our receptionist immediately. **We are not authorized to treat you for this type of claim.** You will need to contact your work supervisor for instructions on how to file a worker's compensation claim.

Disability & FMLA: We ***do NOT*** preform disability assessments, so ***NO*** FMLA, Long Term Disability, or Short Term Disability paperwork will be completed by Athena Family Medicine.

Home Health Care: Patients who required Home Health care, must first be seen by our physician for a face-to face evaluation and a referral can be made to a Home Health agency.

Durable Medical Equipment / DME: Patients who required DME / orthotics, must first be seen by our physician for an evaluation and specific orders will be made by our physician.

OFFICE POLICY

In Office Medical Procedures: Our physician routinely ***does not*** perform **MAJOR** in office medical procedures, except for minor skin procedures with Cryotherapy. **A procedure consent is required.**

Corticosteroid Injection: Our physician typically performs corticosteroid joint injections and trigger point injections for pain management**. A procedure consent is required**.

Hospital / ER Discharge Follow Up: Please let us know prior to your clinic visit if your appointment is for a hospital or ER follow up visit. ***Please bring all documents, labs, x-ray, MRI, discharge summary, name of hospital or ER and date that you were seen.***

Medical Records: We will provide you a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

X-Rays / Imaging: x-rays and other imaging can be requested by patients directly from the Imaging Center. Patient may be required to sign a medical release form from the Imaging Center.

Collections: Accounts that are not paid within 30 days, will begin our in house collection process. If your balance becomes 65 days old, your doctor will be notified and you may be subject to dismissal from the practice.

Billing: If you receive a bill from us, please contact your insurance company first. If you have any questions about your bill, please call us immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Insurance: We accept most commercial insurances.
We *do NOT* accept, and are out-of-network with Humana, Molina, or Medicaid.

Thank you for choosing **Athena Family Medicine** as your Primary Care Provider.

Acknowledgement

I acknowledge that I have received and read a copy of the **Athena Family Medicine and Financial Policies.**

Patient Name: _____

_____ _____
Signature/Patient or Guardian **Date**

Rockwall Location
810 Ralph Hall Pkwy, Suite 110
Rockwall, TX 75032
469-402-3434

Rowlett Location
8301 Lakeview Pkwy, Suite 106
Rowlett, TX 75088
469-931-2602

ATHENA FAMILY MEDICINE

KEVIN VO, M.D.
Board Certified Family Medicine

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO ATHENA FAMILY MEDICINE

PLEASE COMPLETE ENTIRE FORM

Name of Facility: I hereby authorize _____to release health records information on:

Patient Name:_____ Date Of Birth:_____ Social Security #_____

Patient Phone Number Primary#: _____Secondary#:_____

For Healthcare Covering the Periods from _____To:_____ OR _____ all dates

For the purpose(s) of: _____

PLEASE RELEASE RECORDS TO:

ATHENA FAMILY MEDICINE
8301 LAKEVIEW PKWY, SUITE 106
ROWLETT, TX 75088
P: 469-931-2602
F: 469-931-2623

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes**, I consent to the release of this information. ☐ **No**, I do not consent to the release of this information.

REVOCATION: I understand that this authorization maybe revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

Medical care is not conditional upon the signing of this authorization.

Patient name: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO ATHENA FAMILY MEDICINE

WARNING: Your Personal Health Information (PHI) may be re-disclosed by the receiving entity.

I understand that there may be a fee for preparing and furnishing this information

_____ _____ _____

Signature of Patient or Legal Representative Relationship to Patient Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold any staff member liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

_____ _____ _____

Signature of Patient or Legal Representative Relationship to Patient Date

Preparation Fee $25.00 for the first 20 pages $0.50 per additional page Copy OF Billing Records $25.00

TO BE COMPLETED BY ATHENA FAMILY MEDICINE ONLY

Date request completed _____ # pages copied _____ Charges $ _____

Send out by _____ Method _____Mailed _____Faxed _____ Picked up