ΣCare Medical Group
Patricia H. Janki M.D., P.A.
Occupational Medicine • Family Practice • Travel Medicine • Preventive Medicine • Wellness Center

13601 Woodforest Blvd.
Houston, TX 77015
Phone: (713) 330-4325 Fax: (713) 330-1910

We Accept: Visa * MasterCard * and Cash Only * No Checks Accepted

PATIENT INFORMATION:

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

SSN: _____-_____-_____ **Date Of Birth:** _____/_____/_____**Driver License #** _____

Telephone Numbers:

Home: (____) _____-_____ **Work:** (____) _____-_____ **Cell:** (____) _____-_____

Emergency Contact: _____ **Relationship:** _____ **Phone Number:** (____) _____-_____

Employer:_____**Occupation:** _____

Employment Status: □ **Full-Time** □ **Part-Time** □ **Student** □ **Retired** □ **Un-Employed** □ **Housewife**

Marital Status: □ **Single** □ **Married** □ **Divorced** □ **Separated** □ **Widowed**

Race: □ **Native American** □ **Asian** □ **Caucasian** □**African American** □ **Unknown** □ **Refuse to Report** □ **Other:**_____

Ethnicity: □ **Hispanic/Latino** □ **Not Hispanic/Latino** □ **Refuse to Report** □ **Unknown**

Language Preference: □ **English** □ **Spanish** □ **Other:**_____

E-Mail Information:

Can we contact you via E-mail? □ **Yes** □ **No**

If yes, we will use your e-mail address as a way to communicate with you when test results are normal or if we cannot contact you in any other way. Your personal email will be used only for confidential matters pertaining you.

Confidential E-Mail: _____@_____._____ **Is it Confidential?** □ **Yes** □ **No**

Insurance Information: (If it applies) □ **Check Here If No Insurance**

Insurance Name: _____

Name of Insured: _____**Relationship:** □ **Self** □ **Spouse** □ **Parent** □ **Other**

Insured's Information: (If other than self)

Date of Birth: ____/_____/_____ **SSN:** _____-_____-_____

Employer: _____ **Occupation:** _____

Financial Agreement and Authorization for Treatment

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I authorize treatment and agree to pay all fees and charges for the person named above. I agree to pay all charges shown by statements promptly upon their presentation, unless credit arrangements are agreed upon in writing. I authorize payment directly to **PATRICIA H. JANKI, M.D. P.A. – E Care Medical Group** insurance benefits otherwise payable to me. I hereby authorize the release of any medical information necessary in order to process a claim for payment in my behalf.

Signature:_____ **Date:**_____

Revised 12/17/2018

HEALTH AND HISTORY

What is your current occupation?						
Illness / Injuries: Please check if you have ever had or if present in the family:						
Illness / Injury	*Yes*	*No*	*Illness / Injury*	*Yes*	*No*	*If Yes, explain:*
High Blood Pressure			STD's			
Diabetes			Yellow Jaundice			
Fainting Spells			Hepatitis			
Peptic Ulcers / Bleeding			Kidney Stones			
Heart Attack / Murmurs			Lung Problems			
Chest Pain / Tightness			Stomach Problems			
Shortness of Breath			Thyroid Problems			
Stroke			Childhood Disease			
Cancer			Asthma			
Anemia			Back/Joint/Ligament			
Skin Allergy / Reaction			Broken bones			
Gallstones			Any Disability			
Depression / Anxiety			Loss of Fingers/Limb			
What would you like to discuss today with the Clinician?						
ALLERGIES TO DRUGS:						
Personal Habits / Risk Factors						

Habit / Risk Factors	*Yes*	*No*	
Do you have any Pets?			What type:
Do you have any hobbies?			What type:
Is your job a risk to your Health?			Explain:
Are you married?			Status:
Are you and your partner monogamous (no other sex partners)?			
Recent Travel?			To Where:
Are you concerned about your health?			Explain:

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Do you exercise?			What type:	
Immunizations:	**Date:**			**Date:**
TB/PPD Skin Test			Hepatitis A	
Influenza/Flu Shot			Hepatitis B Series	
Pneumococcal/Pneumonia Shot			Tetanus	
FEMALES ONLY:				
Are you Pregnant? Yes No			How many children have you delivered?	
Date of last Menstrual Period:			Is your cycle regular? Yes No	
For Pediatric Patients Only:				
Birth Height:			Birth Weight:	
Complications at birth or during pregnancy? Yes No			Is Child up to date with immunizations? Yes No	

The above information is true and accurate to the best of my knowledge.

Patient Signature, or guardian if patient is a minor: _____ Date: ___/___/___

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Depression Screening

Questions:	**Not at all**	**Only slightly**	**Partly**	**Quite a lot**	**A lot**	**To a great extent**
I do everything slowly.	○	○	○	○	○	○
My future seems hopeless.	○	○	○	○	○	○
I find it hard to concentrate when I read.	○	○	○	○	○	○
All joy and pleasure seem to have disappeared from my life.	○	○	○	○	○	○
I find it hard to make decisions.	○	○	○	○	○	○
I have lost interest in things that used to mean a lot to me.	○	○	○	○	○	○
I feel sad, depressed and unhappy.	○	○	○	○	○	○
I feel restless and cannot relax.	○	○	○	○	○	○
I feel tired.	○	○	○	○	○	○
I find it hard to do even trivial things.	○	○	○	○	○	○

Questions:	**Not at all**	**Only slightly**	**Partly**	**Quite a lot**	**A lot**	**To a great extent**
I feel guilty and deserve to be punished.	○	○	○	○	○	○
I feel like a failure.	○	○	○	○	○	○
I feel empty - more dead than alive.	○	○	○	○	○	○
My sleep is disturbed: Too little, too much or disturbed sleep.	○	○	○	○	○	○

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I wonder HOW I could commit suicide.	○	○	○	○	○	○
I feel confined and imprisoned.	○	○	○	○	○	○
I feel down even when something good happens to me.	○	○	○	○	○	○
I have lost or gained weight without being on a diet.	○	○	○	○	○	○

Patient Signature, or guardian if patient is a minor: _____ Date: ___/___/___

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Patricia H. Janki. M.D., P.A. **Treatment Authorization Form**

Patient Name _____ **Date** _____

Consent for Treatment: I authorize Dr. Janki and associates to perform the necessary drug test, physical examination, and/or to render the necessary medical treatment as approved by the guidelines from Texas Medical Board (TMB) and American Academy of Family Physicians (AAFP). This includes, but are not limited to, medical examination, diagnosis, x-rays, medical procedure(s), and diagnostic laboratory test to be performed by the designated clinical staff. Treatment maybe rendered by Physician or Physician Assistant._____ (Initials)

Only if work related: I voluntarily give consent to Dr. Janki's clinic to obtain any specimen of my urine, blood, saliva, hair and/or breath for the purpose of screening for the presence of drugs and/or alcohol, if necessary**. I give authorization to release my information to my employer, prospective employer and workers' compensation carrier when applicable. I understand that I will only be treated for the designated injury as by my employer. I understand that there is no recognized Doctor- Patient Relationship, and that Dr. Janki will only perform a limited physical exam. For a more thorough exam I must go to my primary physician.** _____ (Initials)

Release of Medical Records: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, or any physician who referred me here, or to whom I may be referred. _____ (Initials)

FAMILY PRACTICE/OTHERS
Insurance Authorization/Financial Agreement: I request that payment of authorized benefits be made to Dr. Janki on my behalf, for any services provided to me. I authorize any medical and other information about myself to be released to, but not limited to: Medicare and its agents, any insurance company, any other third party payer, state medical assistance agency, utilization review organization or any other governmental or private payer responsible for paying such benefits and any information needed to determine these benefits or benefits for related services. I agree to pay for all charges not covered by a third party payer. I understand that it is my responsibility to pay all deductibles, co-pays, and charges for medical services rendered that are not covered by my insurance at the time of service. It is my responsibility to verify my insurance eligibility and should my account be referred for collection, then the undersigned shall pay the necessary collection expenses or attorney fees._____ (Initials)

Pre-Certification of your Benefits:

- We advise that you have a print-out of your benefits at each visit. The print-out must have the date of your scheduled visit. This will expedite your wait time by verifying your benefits.
- It is important that you understand your benefits. All payments that you owe are to be paid at time of service.
- Incorrect pre-certification may result in your responsibility of the total payment. _____ (Initials)

Confidentiality: It is Dr. Janki's clinic policy to protect all medical records against loss, theft, tampering, destruction and access by unauthorized persons per HIPPA guidelines.

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I understand and give Dr. Janki permission for my medical records to be periodically reviewed by appropriate utilization committee, quality assurance personnel, TWCC, Workers Compensation Carriers, third party payers, employers and national accreditation or certification committees. _____ (Initials)

Medication refills will be provided only when considered appropriate by Dr. Janki and/or the provider.

- A patient must be evaluated before receiving a prescription.
- We require a 48 hour notification for a refill request.
- Please call your pharmacy before you run out of medication to request a refill and the pharmacy can communicate your request with the Doctor's office via HIPPA compliant methods.
- **If a narcotic, muscle relaxant, or tranquilizer is lost, it will not be replaced or refilled.**
- We DO NOT refill antibiotics, narcotics or medications for acute conditions without reevaluating the patient, a follow up appointment is mandatory.
- Medications for chronic conditions must be refilled every 90 days after your office visit in order to comply with the "Quality of Standards." Patients do not receive refills for a year even if they might have a stable chronic condition. Patients taking narcotics, muscle relaxants or tranquilizers receive 30 day prescriptions and must follow up for reevaluation before another 30 day prescription may be dispensed. Revised 12-17-2018

- Patients on antidepressants, antianxiety or any other class of drug deemed relevant by the provider may be referred to a Specialist, Psychiatrist or Psychologist to verify medical necessity before the drug is prescribed.
- If you feel that your medication is not helping your condition, please call the office and notify a nurse or Dr. Janki immediately. **Do not adjust your dosage without Dr. Janki's or the providers' approval**. _____ (Initials)

Lab Results: Patients Lab Results and Test Results are ONLY discussed in person with the provider after they become available usually within a week from when they are drawn. **No** Lab Tests or Results will be communicated over the phone. _____ (Initials)

Patient Confirmation of Receipt of Privacy Practices:

I, _____, acknowledge receipt of Patricia H. Janki, M.D. P.A. Privacy Practices and understand that my medical information may be shared with other persons as explained in my HIPAA Rights.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

Urgent Care/After Hours/No Appointment/Same Day Appointment

- We will be happy to see you.
- You may have to wait until our patients with pre-scheduled appointments are seen, even though you may have arrived first.
- You will only be seen for your presenting problem.
- **No wellness exams, full physicals or pap smears will be performed, since this type of visit requires additional time and must be pre-scheduled**.
- If you have small children, please keep them seated and quiet in order to be considerate of our Staff and ill patients.

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On Saturday hours or after normal business hours, your visit will be charged the "Urgent Care/After Hours co-payment or consultation fee/charges.

_____ _____

Patient Signature **Date**

Cancellation of Appointment and No Show:

- We understand that there may be extenuating circumstances whereby you may not show up for your appointment. However, cancellations are permitted 24 hours prior to your appointment in order to accommodate other patients to be seen.
- Any **cancellations after that, will incur a $25.00 fee** that will be billed to you. _____(Initials)

I authorize a copy of this authorization to be used in place of the original.

I _____, have fully read and/or was explained to me with ample time the above
(Print Patient Name)

Contents and Policies. I fully understand and accept its contents in its entirety.

Patient Signature: _____ **Date** _____/_____/_____.

If patient < 18 years old, biological parent or legal guardian must sign below:

I authorize Dr. Janki to evaluate and treat my child.

Signature: _____**Print**_____ **Date** _____/_____/_____

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Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. 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 expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some, and perhaps all of the services you receive may be non-covered or not considered as reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise agreed upon by both parties. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our Physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

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

_____ _____

Signature of Patient and/or Responsible Party **Date**

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Immunizations and Vaccinations Policy

Dear Patients:

Please be advised that effective September of 2011 ALL IMMUNIZATIONS / VACCINATIONS will need to be paid for in full at the time of service. We will no longer take insurance for the Immunizations and Vaccinations. We apologize for the inconvenience this may cause. Our office is committed to providing the best treatment to our patients.

Should have any questions or need additional information regarding prices you are welcome to ask the Front Desk Personnel for assistance. Each immunization and vaccination has an individual price and not all are the same price. Our prices are representative of the usual and customary charges for our area.

By signing I acknowledge and understand that it is my responsibility to pay in full the Immunizations / Vaccinations administered to me.

Signature: _____ Date: ____/____/_____

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

Revised 12-17-2018

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Release of Medical Records

I _____, authorize the following Physician:
Name (Please Print)

_____
Hospital and/or Medical Facility to release the records requested below to:
Dr. Patricia H. Janki, M.D. in order to continue with my Medical Care and/or Treatment.

- ☐ All Medical Records
- ☐ All lab Results
- ☐ X-Ray Results
- ☐ Other: _____

- ☐ No Previous PCP

Physician Name: _____

Physician Specialty: _____

Phone Number: (___) _____ Fax Number: (___) _____

Patients Name: _____DOB:_____

_____ _____
Patient Signature **Date**

_____ _____
Witness Signature **Date**

Please fax the requested records to (713) 330-1910 as soon as possible so that we may provide the patient with the appropriate Medical Care. If you have any questions requiring our request please

contact us at (713) 330-4325.

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Walk In Policy

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- We are glad to accommodate you today. However; you may have to wait a while until our patients **with** appointments are seen.
- You will be seen today as we will **work you** into our schedule.
- You can only be seen for your **presenting problem**.
- **NO ANNUAL EXAMS/ROUTINE PHYSICALS/WELLNESS EXAMS.** (For these services you must schedule an appointment)
- If you have had an appointment but you arrive more than ten (10) minutes late, then the above policy applies to you since you have lost your appointment time.

I have read and understand this policy. **I understand that I may have to wait perhaps over an hour depending on the schedule. However, we do take pride in accommodating all of our patients on the same day of illness and thus we will try to check you in ASAP.**

What is the **reason** for your visit today? _____

Print Name: _____ Signature: _____Date: _____

Your financial obligation and Follow up Visit is scheduled on: ___/___/____ at___:_____ AM / PM

To ensure continuity of your care and proper attendance to your health issues and wellness, you will have a face to face discussion with one of our providers to discuss lab results and follow up of your prior symptoms if applicable, and wellness exam. Our Medical Assistants are not qualified to make medical decisions.

Therefore, you **MUST** pay your co-payment and your insurance will be billed. We are not able to waive your co-payment as it is required per your insurance carrier and this will be fraudulent if we do not collect it which is part of your payment for your visit today. You are also responsible for all bills or lapses of your insurance not covered by your policy._____ (Initials)

Revised 12-17-2018