

**Krystal Bewley, FNP-C & Polly Klement, FNP-C**

**Chance Dingler, MD**

**909 North Frontage Rd**

**Valley View, TX 76272**

**Phone: 940-726-5750 Fax: 940-726-5721**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity/Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Physician (including location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy (including location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Valley View Family Medical Clinic?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of medical information necessary to process my insurance claim and assign the doctor all payments from Medicare and other insurance carriers for services rendered. I also understand that I am responsible for the balance of my account. I understand and agree to the above conditions.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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ACKNOWLEDGE OF REVIEW OF PRIVACY PRACTICES

I hereby certify that I have been given the opportunity to review Valley View Family Medical Clinic’s

NOTICE OF PRIVACY PRACTICES, which explains how my protected health information will be used and disclosed. I understand that I am entitled to a copy of this document if I chose to have one.

COMMUNICATION AUTHORIZATION

and RELEASE OF INFORMATION TO AUTHORIZED REPRESENTATIVES

I give Valley View Family Medical Clinic permission to:

Leave a message on your voicemail / home messaging system regarding appointments, lab results, imaging reports or other such diagnostic reports? ⃞⃞ YES ⃞ NO

Contact me at work (in emergency circumstances only) with lab results, imaging reports, other diagnostic test results or urgent health issues? ⃞⃞ YES ⃞ NO

Discuss your health care issues with any member of your family or other authorized persons that I chose and have listed below? ⃞⃞ YES ⃞ NO

If yes, please list the person(s) that are authorized below:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**AUTHORIZATION TO OBTAIN MEDICAL INFORMATION**

I understand that my medical records are confidential and cannot be disclosed without my written authorization, except as otherwise provided for by law. I hereby voluntarily authorize Valley View Family Medical Clinic to obtain my medical information on my behalf. I understand that I may revoke this authorization at any time by notifying Valley View Family Medical Clinic in writing of my intent to revoke this authorization, and understand that such revocation will not have any effect on the actions taken by the office prior to the revocation. I understand that once my information is received that it may be disclosed by Valley View Family Medical Clinic to those with similar authorization. I understand that I may be asked to show proof that I have the authority to sign an authorization of this nature. I understand that I may be charged for copies of my records which I have requested for my personal use. I also understand that fees for copies are due and payable prior to copies being released. I understand that a photocopy or facsimile of this authorization is as valid as the original.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legally Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Patient: ⃞⃞⃞ self ⃞ parent / legal guardian ⃞ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

INFORMATION TO BE OBTAINED

From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Types of Information:

⃞ All previous medical records

⃞ Records from recent hospital stay / ER visit

⃞ Office note from most recent visit

⃞ Imaging

⃞ Lab reports

⃞ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request processed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Valley View Family Medical Clinic - Office Policies**

Prescription Refill Policy-

* When you require a refill your medication, please call your pharmacy and have them send us a prescription refill request to our office, even if you are out of refills. This is the most efficient way to process a refill.
* Please allow 48 hours for refills to be processed. To ensure that you do not run out of your medication, please plan ahead and do not wait until you are out of medication to request a refill.
* If you are due for a follow up appointment or have missed a scheduled appointment, we are not obligated to refill your medication. Please discuss with your provider at each visit about when you are due back in the office for a follow up visit.

Telephone Message Policy-

* When leaving a message for our office staff we must pull your chart, review your records, discuss a plan of action with provider, and create legal documentation for the phone call. Please allow an adequate amount of time to return your call that we may provide the best possible care. If you are experiencing an emergency, please do not hesitate to call 911 or go to the nearest emergency room.

Outpatient Testing and Referrals Policy-

* Please allow 24 to 48 hours for our staff to arrange non emergency testing / imaging and to process any referrals to specialists. This time is needed to send your records and for the facility receiving your orders to make arrangements with your insurance company. If you have an HMO insurance plan, referrals require prior authorization. This process can take up to 5 business days to complete.
* We often send orders directly to outside facilities so that they may contact you to make appointment arrangements. If you have not heard their office / facility in 48 hours, please contact us so that we can check on the status of your appointment.
* When we receive your test results you will receive a phone call from our office staff with a preliminary report. Please remember that this courtesy call should not be considered a follow up and does not take the place of a face to face appointment with the provider if indicated.

Lab services -

* As a convenience for our patients, we act as a draw site for CPL, Labcorp, and Quest. We will send your insurance information to the lab and they will bill for your lab testing. It is your responsibility to be aware of your lab benefits through your insurance policy. Self pay rates are available for those without insurance. If you have any questions regarding the cost of labs, please speak to our office staff.

Financial Policy-

* If you have an insurance policy that we are in network with, we will be glad to file a claim on your behalf. If you are self pay or your insurance requires a copay, coinsurance, or deductible payment, the full amount due as well as any past due balances are due at the time or service and will be collected before seeing the provider. If you have any questions or concerns regarding billing please let us know so that me may get you in contact with ABC Professionals as they are our billing company.

Controlled Substance Policy-

* In order to provide safe medical care as well as conform to the guidelines of the Drug Enforcement Agency, all controlled substance medication will require routine face to face follow up appointments for prescription refills. Examples of these types of medications include, but are not limited to: pain medication, sleep medication, benzodiazepine anxiety medications, testosterone, and stimulant medications such as diet medication and medications that treat ADD/ADHD. Some of these types of medications may also require additional medication specific consents to be signed as well.

**I hereby certify that I have read the policies of Valley View Family Medical Clinic, have been given the opportunity to ask questions, and I fully understand and agree to the policies as stated above.**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_