Dr. Stanley Franklin

MEDICAL HISTORY

We need to know your past medical history to best understand how we can help you. The information on this form will be kept confidential and will not be released unless you request the release.

Drug Allergies:
_____

Date: _____

Name: _____Age: _____
Date of Birth: _____

Marital Status: M S D W
Date of last Gynecological Exam: _____

Number of: ____Pregnancies ____Miscarriages ____ Stillborn ____ Living Children

Method of Birth Control: _____

Pharmacy _____ Phone _____
Address _____

Reason for Today's Appointment (Circle):

Annual Exam and Pap smear Pregnancy Infection Pelvic Pain Breast Lump/Pain

Other:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

MEDICATION LIST

PATIENT NAME_____ Date_____

MEDICATION	DOSAGE	FREQUENCY

Dr. Stanley F. Franklin, M.D. PA
REGISTRATION FORM
(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( )

City: | State: | Zip Code: | Cell phone no.: ( )

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? Yes /No Primary Insurance

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ *Date* _____

Stanley F. Franklin M.D., P.A.

CENTER FOR GYNECOLOGY

541 W. Main St. Ste. 101, Lewisville, TX 75057 • Phone 972-420-8585 • Fax 972-221-4892

PATIENT WAIVER
IMPORTANT INFORMATION – PLEASE TAKE TIME TO READ!

To our Patients:

Many insurance companies today do not cover preventive services (annual physicals, immunizations, screening tests, infertility, weight management, depression, etc.)

We do our best to verify your coverage prior to your visit, **but we cannot guarantee payment of benefits by your insurance plan.** This is a contract between you and your insurance company and it is **YOUR** responsibility to know the terms of your plan.

Some (but not all) of the services that may not be covered by insurance are:

Immunizations: Influenza, Cervarix

Screening test: Cholesterol, Diabetes, Thyroid, Vitamin D

An annual well woman exam or general physical is preventive in nature and consists of a physical exam, Pap test for women, and **refills of birth control prescription medications. These exams are not to be used to treat or discuss any medical problems.** Insurance companies are also **very** particular that your **annual exam must be scheduled exactly one year from the date of your previous exam. If you schedule your exam too early, it is very likely the insurance will deny payment and you will be responsible for the charges.**

If there is a problem/concern to discuss or treat, then this is not considered a well woman exam or physical and will be billed either as a new or established problem office visit. We are required by insurance company guidelines to submit our bill to your insurance company using accurate information about the type of service you received. **PLEASE DO NOT ASK US TO CHANGE THE CODING OF YOUR VISIT AS THIS IS INSURANCE FRAUD!**

In the event you are referred to a specialist, please keep in mind that the referral is based on quality of care and not insurance acceptance. **It is YOUR responsibility to confirm with the specialist's office to ensure their acceptance of your insurance.**

I understand that I am responsible for full payment to Dr. Stanley Franklin for any services that may not be covered by my insurance plan.

_____ _____

Patient Signature Date

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FINANCIAL POLICY STATEMENT

IMPORTANT INFORMATION PLEASE READ

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT IS DUE IN FULL AT TIME OF SERVICE; unless other arrangements have been made in advance. FOR OUR UNINSURED PATIENTS A **20%** DISCOUNT WILL BE APPLIED WHEN PAID IN FULL UPON CHECK OUT. For your convenience we accept cash, check, Master Card, Visa and Discover. Your insurance policy is a contract between you and your insurance company, the doctor is not involved.

Your insurance policy is a contract between you and your insurance company, the doctor is not involved.
As a courtesy to our patients, we will bill contracted insurance plans directly. Any co-payment and/or co-insurance or deductible is payable at the time of service. Payments not received within thirty (30) days of statement date are considered late. Interest on late payments will accrue at a rate of 1.5% monthly. Past due accounts will result in the account being sent to our collection agency. Patient agrees to pay collection cost at an additional 30% of total balance on each account sent to collections. Any patients sent to collections will be dismissed from the practice until the balance is paid in full. No services will be rendered by this office (appointments or prescription refills) until the balance is paid in full.

I have read and understand this financial policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice.

_____ _____
Signature of Patient Date

_____
Name of patient (please print)

Texas Health
Presbyterian Hospital
FLOWER MOUND

DISCLOSURE OF PHYSICIAN OWNERSHIP IN HEALTHCARE FACILITIES

Please carefully review the following information:

Your physician, Dr. Stanley Franklin, is required by federal and state law to disclose any ownership or financial interest in any healthcare facilities to which our patients may be referred. Your physician holds an ownership interest in Texas Health Presbyterian Hospital Flower Mound ("THFM"). Please contact the scheduler at THFM for a current list of physician owners or go to www.texashealthflowermound.com.

We respect your right to choose not only your physician, but also where you wish to receive medical care. You will not be treated differently by your physician if you choose to use a different facility. We encourage you to ask questions or discuss any concerns you have with us at the time of your office visit.

ACKNOWLEDGMENT:

I have been notified, at the time of referral, that my physician and other treating physician(s) have an ownership interest in Texas Health Presbyterian Hospital Flower Mound. I further acknowledge this disclosure will be maintained in my medical record and made available to Texas Health Presbyterian Hospital Flower Mound.

Patient Name (please print) _____

SIGNATURE:

Patient: _____ Date: _____

OR

Legal Representative: _____

Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative

_____

Signature

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AUTHORIZATION OF USE/ DISCLOSURE OF PROTECTED INFORMATION

Appointment reminders: Typically, appointment reminder are brief non-specific message that may be left on your answering machine or messages sent to you cellular phone.
How would you prefer to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for service provided by Dr. Stanley F. Franklin. (Check all that apply)

Regular mail_____Appointment cards_____Phone/voicemail_____
Cell#_____Work#_____

OK TO LEAVE VOICE MESSAGE-(CIRCLE ONE)
YES or NO

Other Uses and Disclosures: Disclosure of your health information or its use for any purposes other than those listed in the "Notice of Privacy Policies and Practices "consent will require your specific authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke will not affect or undo any disclosure prior to your notification date. You have the right to request restrictions on use and disclosure of your health information. **Please list any restrictions below:**

PERSONS AUTHORIZED TO RECEIVE INFORMATION:

Name of person/relation/organization Phone #

Name of person/relation/organization Phone #

Print Patient Name

Signature of Patient Date
Patient Representative Signature/ relationship to patient

Stanley F. Franklin M.D., P.A.

REVIEW OF SYMPTOMS

Name: _____

DOB: _____

FAMILY HISTORY: ☐ No knowledge of family medical history

Relation	Age	Health Issues	If deceased cause and age
Father			
Mother			
Brothers/Sisters			
Children			

Please indicate medical conditions that run in your family. Please indicate also who is affected by these conditions.

	Asthma :
	Seizures
	Cholesterol:
	Allergies:
	Mental Illness:
	Alcoholism:
	Lung Dis.:
	Diabetes
	Ulcers:
	Kidney Dis.
	Other:
	Cancer:
	Breast::
	Colon:
	Brain:
	Lung:
	Skin:
	Other:

	Headaches:
	Liver Disease:
	Hypothyroid (Low):
	Hyperthyroid (High):
	Heart Attacks:
	High Blood Pressure:
	Stroke:
	Arthritis:
	Reflux:
	Blood Disease
	Heart Disease

Patient Signature/Date:

_____

_____