Attention Patients

Ancor Health Center treats most medical ailments, but does not accept patients for pain management purposes or for chronic psychological conditions.

If you require perscriptions of pain medicine, such as Vicodin, Lortab, Oxycontin, Percocet, Rabaxim, Xanax, Valium or other controlled drugs, we will gladly refer you to a pain management specialist or psychiatrist. We prescribe thesse and similar medicines for acute purposes only. We do not prescribe them for chronic problems.

Our providers will be happy to treat your medical problems and welcome you to our clinic.

Respectfully,

Ancor Health Center, PA

Today's Date:					
Patient Information					
Name		Preferred Language			
Address		City, State		Zip code	
Home Phone	Cell Phone	Work Phone	Email		
Birth Date	Age	☐ Male	☐ Female		
Preferred Way to Contact You: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email *By making a contact selection you are giving us permission to contact you.*					
Employer/School					
Emergency Contact		Relationship		Phone	
How did you hear about us?					
Financial Responsibility					
Person Responsible for Account		Relationship to Patient			
Address		City/State		Zip Code	
Home Phone	Cell Phone	Work Phone	Employer		
Birth Date	SS#		☐ Male	☐ Female	
Primary Insurance					
Insurance Company		Phone #			
Address		City/State		Zip Code	
Subscriber Name		ID #		Group #	
Birth Date		SS#			
Secondary Insurance					
Insurance Company		Phone #			
Address		City/State		Zip Code	
Subscriber Name		ID #		Group #	
Birth Date		SS#			

Consent to Treatment

☐ I am the patient or	☐ I am the parent/guardian of the patient or	☐ Other Relationship

I hereby authorize such medical care, treatment, and diagnostic tests as may be recommended and understand there is no warranty or guarantee of result or cure. This consent will remain in effect until I withdraw my consent in writing.

Name DOB Reason for Visit

Medical History

Allergies (Drug, Food , Environmental, Etc.):

Surgeries and Date:

When was your Last:

Mammogram (35 YRS)	Self Breas Exam	Self Testicular Exam

Immunization History:

Diphtheria/Tetanus	Flu Vaccine	Pneumonia Vaccine

Family Medical History (Circle Yes or No) and list family member (Mother, Father, Sibling):

Cancer:	Yes	No	Heart Trouble:	Yes	No
Diabetes:	Yes	No	High Blood Pressure	Yes	No

Have you had any of the following? Circle Yes or No

Y	N	High Blood Pressure	Y	N	Anemia
Y	N	Diabetes	Y	N	Phlebitis
Y	N	Glaucoma	Y	N	Abnormal Bruising
Y	N	Headaches	Y	N	Abnormal Bleeding
Y	N	Eye Disease	Y	N	Cancer
Y	N	Ear Infections	Y	N	Peptic Ulcer Disease
Y	N	Asthma	Y	N	Gallbladder Disease
Y	N	Chest Pain or Angina	Y	N	Hepatitis/Jaundice
Y	N	Shortness of Breath	Y	N	Blood in Stool
Y	N	Excessive Bleeding after Surgery/	Y	N	Hemorrhoids
Y	N	Tooth Extraction	Y	N	Recent Change in Bowl
Y	N	Arthritis	Y	N	Cramping/Pain Abdomen
Y	N	Pneumonia	Y	N	Kidney Trouble/Stones
Y	N	Heart Murmur	Y	N	Thyroid Disease
Y	N	Slow Healing After Cut	Y	N	Sleeping Problems

Y	N	Convulsions Seizures	Y	N	Difficulty Starting Stream
Y	N	Numbness/Tingling Sensations	Y	N	Prostrate Problems
Y	N	Fainting Spells	Y	N	Testicle Pain/Swelling
Y	N	Thirsty More Than Usual	Y	N	Blood in Urine
Y	N	Considered Suicide	Y	N	Other: ___________________________________

Gynecological:

Date of Last Menstrual Period	Number of Pregnancies
Date of Last Pap Smear	Any Miscarriages

Do you or have you ever smoked? Yes No # of Cigarettes per day _____________ # Years _________

Do you drink alcohol? Yes No # of Drinks per week _____________

Do you use drugs? Yes No

Parent Signature: ____ Date: ____________________

Thank you for choosing Ancor Heath as your health care provider. A patient information sheet and current insurance information is required before seeing the provider. You will required to follow all registration procedures, which including updating or verifying personal information, presentng verification of current insurance and pay any co-pays or other patient responsibility amount at each visit. Your card or other insurance verfication mus be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as self-pay patient. As a self-pay patient, Ancor Health's fee is expected to be paid in full at the time of service.

The following are Ancor Health's requirements for payment of medical services:

Regarding Self Pay for Service Patients

Ancor Health requires self pay patients to pay the payment in full for the services provided to patients with no insurance Payments can be made by cash, check, money order, or credit card.

Regarding Insurance

Ancor Health will accept assignment of benefits from your primary insurance and one other insurance. A copy of your insurance card(s) is required by our office, and any changes must be brought to our office. If your policy has a deductible or patient responsibility of a co-pay, then you will be required to make that payment at the time of service. Failure to provide our office with current insurance information leads to non-payment from the insurance company and will result in the balance being transferred to patient responsibility.

Regarding Non-Covered Services

Please be away that Medicaid and some insurance companies consider certain services as non-covered services, therefore, you will be expected to pay for these services.

Regarding Insurance Plans Where We Are a Participating Provider

All co-pays and deductibles are due prior to treatment.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area.

I have read and agree to abide by the terms of this financial policy

Signature of Parent/Responsible Party ____________________ Date ____________________

818 N. Fourth Street
Longview, TX 75601
903-236-8600
903-236-8605 (Fax)

Non-Sufficient Funds (NSF)

Ancor Health Center will charge a minimum of $30.00 for any payment that has been returned as a non-sufficient funds (NSF). Ancor Health Center will notify the responsible party of the non-sufficient fund check by mail. The responsible party has seven business days to pay the non-sufficient fee of $30.00 to Ancor Health Center. If the non-sufficient fee has not been paid it will be applied to the responsible parties' balance. If a non-sufficient fund has occurred, Ancor Health Center will no longer ***accept checks*** from the responsible party.

____ ____________________________
Print Responsible Party Name Date

____
Signature of Responsible Party Name

818 N. Fourth Street
Longview, TX 75601
903-236-8600
903-236-8605 (Fax)

Acknowledgement of Privacy Practices

I, ____ acknowledge that I have read and understand the Notice

of Privacy Practices as given to me this _______________ day of _________________________ 20 ___________.

Signature: ____

Printed Name: ____

Witness: ____

Patient Name: ____

818 N. Fourth Street
Longview, TX 75601
903-236-8600
903-236-8605 (Fax)
www.ancohealth.com

Permission to Disclose Relevant Health Information to Friends and Family

If you desire to have certain family members or other specific people receive your personal protected health information on on your behalf, you should provide their information below. We value your privacy and ask that you help us identify the individual's with whom you would like us to discuss your treatment.

Please identify anyone you wish Ancor Health Center to discuss your relevant health information with:

☐ I GIVE PERMISSION for Ancor Health Center to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below:

Name: Relationship:	Name: Relationship:
Name: Relationship:	Name: Relationship:

Patient's Signature: ____ Date: ___________________________

Patient's Printed Name: ____

* Patient is a minor (_______ years of age)* OR is unable to give permission because:

Signature of Individual Signing on Behalf of Patient: ___________________________________ Date: _________________

Legal authority to act on the patient's behalf: ____

******* Office Use Only *********

Reviewed by: ____

AUTHORIZATION FOR RELEASE OF RECORDS
AUTORIZACION PARA EL LANZAMIENTO DE LOS RECORDS

Previous Doctors Office or Clinic: ____
Anterior Clinica de Doctor: ____
Address/Direccion:____
Phone/Telefono: ____
Fax: ____

To release information to:/ que le de information a:

Ancor Health Center, PA
818 N. Fourth St.
Longview, TX 75601
(903) 236-8600
Fax (903) 236-8605

______________________________________ ______________________________________
Patient Name (Please Print)/Nombre del paciente Social Security #/ Numero de Seguridad Social

____________________________ ______________________________________
Date/Fecha Date of Birth/Fecha de Nacimiento

Circle: Male/Masculino or Female/Femenina

Information to be released: / Information que se puede recibir:

__________ Initial examination/Examinacion Incial
__________ Discharge Summary/Resumen de la Descarga
__________ Follow-up Care Progress Notes/Notas de Progreso
__________ Office Visit Note/Notas de la Oficina
__________ Specia Procedure Results/Notas de Procedimientos
__________ All Records/Todo El Expediente

The above information is released for the following purpose and that purpose only, and other use is forbidden: Establish Care with **ANCOR HEALTH CARE CENTER**. All medical records regarding treatment, hospitalization and outpatient care for my condition including, but not limited to psychological, psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV antibody testing. This authorization will expire (30) days from the date of my signature or as otherwise specified by date, event, or condition as follows:

Parents Signature/Firma de madre/padre: ____

Relationship to Patient/Relacion al paciente: ____

Address: ____

Telephone: ____

Date/Fecha: ___________________________ Witness/Testigo: ___________________________