W. E. Furniss II, M.D.

4800 N. E. Stallings Dr, Suite 109
Nacogdoches, TX 75965
(936) 564-2421

Patient Information

Date _________________

First Name ______________________ Middle Initial ____ Last Name ______________________

Date of Birth ______________________ Social Security Number _________________________

Address ____

City______________________ State ________ ZIP Code ______________________

Main Phone (with answering machine/voice mail for lab results) ______________________

Work/Alternate Phone ______________________

Marital Status (Check One) __Married __Single __ Divorced __ Widowed

Patient Employment Information

Employer ____ Occupation ______________________

Employment Status (Check One) __ Full Time __ Part Time __ Self __ Retired __ Military

Employer Address ____

Employer Phone ______________________ Ext ______

Patient's Spouse Information

Spouse's Name____ Occupation ______________________

Spouse's Social Security Number________________________ Date of Birth _____________________

Employer _____________________________________ Phone ______________________ Ext ______

Parent/Guardian Information

Father's Name____ Occupation ______________________

Employer _____________________________________ Phone ______________________ Ext ______

Mother's Name____ Occupation ______________________

Employer _____________________________________ Phone ______________________ Ext ______

Parent's Home Address____

Parent's Home Phone ______________________

Please Complete the Insured's Information Below

Insured's Name ____________________________________ Relation to Patient ____________________________

Insured's Date of Birth ______________________________ Insured's Social Security # ______________________

Insured's Employment Status __ Full Time __ Part Time __ Retired

Insured's Employer ____

Family History

Family Member	Living or Deceased	Present Age or Age at Death	Major Illness or Cause of Death
Father			
Mother			
Brothers/Sisters (circle gender)			
__ M __ F			
__ M __ F			
__ M __ F			
__ M __ F			
Spouse __ M __ F			
Sons /Daughters __ M __ F			
__ M __ F			
__ M __ F			
__ M __ F			
__ M __ F			

Check if any family members have had any of the following: (identify which member)

__ Allergies __ Cancer __ High Blood Pressure

__ Alcoholism __ Diabetes __ Kidney Disease

__ Asthma __ Epilepsy __ Nervous or Mental Disorder

__ Bleeding tendency __ Heart Disease __ Tuberculosis

__ Blindness __ Hearing Loss __ Other

Have you ever had any of the above? __ Yes __ No If yes, please identify:

____

____

Please list any surgeries or hospitalizations you have had in the past

____

____

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Financial Policy

This is an agreement between W. E. Furniss II, M.D., as creditor and the Patient/ Debtor named on this form.

In this agreement the works "you", "you", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to W. E. Furniss II, M.D.

By executing this agreement, you are agreeing to pay for all services that are received.

Credit Card Guarantee: Unless other arrangements are approved by us in writing, you must guarantee your account with a credit card. However, with the credit card guarantee, you give us permission to charge your credit card if we don't receive you payment by the due date.

Payment options if you have no insurance: You choose to pay by __cash, __ check, or __credit card on the day that treatment is rendered.

Payment option if you have insurance: You choose to pay your deductible and/or copay, if you have one, and any out-of-pocket portions at the time services are rendered by __cash, __ check, or __credit card. We will estimate the amount to be covered by your insurance if you are out of network, and you can pay the difference. Once your insurance company pays, we will refund any excess, or bill you for any shortfall. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: Dr Furniss is a preferred provider on many insurances. Each insurance has its own contracts, copays, and deductibles. Please note that it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. This includes but is not limited to labs, procedures, injections, or any other medical service. If your insurance company requites a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and increase the amount you owe.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the ration of one and one half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%). The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of you account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned Checks and Check Writing: We utilize CheckMate check verification and collection service. In order to accept your check, we must run your driver's license number through the CheckMate system to determine whether or not we may accept your check. Returned or NSF checks are processed by CheckMate. CheckMate will assess a $25 returned check fee and begin a collection process on the balance of the NSF plus the fee. If CheckMate is unable to collect the check, the check will be sent to the county courthouse and a warrant issued on the writer of the check until paid.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. For seriously pasty dude accounts, the account will be reported to the Credit Bureau and will negatively affect your credit rating.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Waiver of Confidentiality: You understand if this account is submitted to a collection agency, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing the treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $25 if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We do not currently file workers compensation.

Personal Injury: Payment of the bill remains the patient's responsibility. We cannot bill a third party for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature mremains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

I have read and understand this agreement:

______________________________	______________________________
Patient's Name	Parent or Guardian (if patient is a minor)
______________________________	______________________
Signature	Date
______________________________	______________________
Co-Signature	Date

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Notice of Privacy Practices Acknowledgement

I have been provided a copy of the practice's Notice of Privacy Practices and have reviewed it in detail. I have been given the opportunity to ask questions about the notice. I understand that my information may be used and disclosed according to the terms of the notice.

If changes are made to the current notice, I understand a revised notice will be given to me on my next office visit. The revised policies and practices will be applied to all protected health information maintained by this practice.

____
Patient Name (Please Print)

____
Date

____
Signature of Patient/Personal Representative

____
Witness Signature

// W. E. Furniss II, M.D.

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Recommendations

Should you have any problems with medication, discontinue the medicines and contact the doctor or the emergency room for serious problems. Should you develop suicidal ideation stop all the medicine and contact the Doctor immediately.

Please inform your family of the medications that you are taking in case you have problems.

Side effects, precautions, and instructions related to medications and illnesses are discussed with the patients and advised of habitual nature of pain medications and anxiety medication. The patient is responsible for taking them as directed.

The patient is reminded that Dr. Furniss is in the office 6 days a week, rounds at Nacogdoches Medical Center 7 days a week with rare exception. If you have problems, come to Nacogdoches Medical Center Hospital or come to the office.

W. E. Furniss II, M.D.

____
Patient Signature

____
Date

____
Witness Signature

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Consent to Treatment

I (we) voluntarily authorize the rendering of medical care, including examination, diagnostic procedures and medical treatment by,

Dr. W. E. Furniss, II and the staff and designee, as may, in his/her professional judgment, be deemed necessary or beneficial.

I (we) acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition.

I (we) understand that I (we) have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures.

____
Patient Name (Please Print)

____
Date

____
Signature of Patient/Personal Representative

____
Relationship to Patient

____
Reason Patient Cannot Sign

____
Witness Signature