RICK-Frisco

Patient Last Name ____________________ Home Phone ____________________

First Name ____________ Middle ________ Work Phone ____________________

Address ____________________ Date of Birth ____________________

____________________ Sex ______ Marital Status ____________

City ____________ State ______ Zip ______ Social Security No. ____________________

Emergency Contact ____________________ Driver's License ____________________

____________________ Women's Specialists Physician ____________________

Patient's Employer ____________________ Occupation ____________________

Address ____________________ Phone ____________ Fax ____________

____________________ E-Mail ____________________

City ____________ State ______ Zip ______ Contact ____________________

Provide the following information if guarantor is different than patient.

Guarantor's Last Name ____________________ Phone ____________________

First Name ____________ Middle ________ Employer ____________________

Address ____________________ SS # ____________ DOB ____________

City ____________ State ______ Zip ______ Patient's Relationship to Guarantor ____________

Primary Insurance, Circle One: ***PPO HMO Other Don't Know***

Company Name ____________________

Claims Address ____________________

City ____________ State ______ Zip ______

Member Services Phone ____________________

Policy No ____________ Group No ____________

Group Name ____________________

Insured Name ____________________

Address ____________________

City ____________ State ______ Zip ______

Phone ____________ DOB ________ Sex ______

Insured Employer ____________________

Address ____________________

Phone ____________ Fax ____________

Patient's Relationship to Insured ____________

Secondary Insurance, Circle One: ***PPO HMO Other Don't Know***

Company Name ____________________

Claims Address ____________________

City ____________ State ______ Zip ______

Member Services Phone ____________________

Policy No ____________ Group No ____________

Group Name ____________________

Insured Name ____________________

Address ____________________

City ____________ State ______ Zip ______

Phone ____________ DOB ________ Sex ______

Insured Employer ____________________

Address ____________________

Phone ____________ Fax ____________

Patient's Relationship to Insured ____________

Provide the following information:

Referred by: ____________________

Has any member of your family ever been treated at this office? Circle One: Yes No

List Current Medications ____________________

Are you allergic to any medicine? Circle One: Yes ____________________ No Don't Know

Pharmacy Name ____________ Pharmacy Phone ____________ Pharmacy Fax ____________

I plan to make payment of my medical expenses as follows:(Circle One or More) Cash/Check MasterCard/Visa Discover

Financial Agreement & Authorization for Treatment

All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been made in advance with our office manager. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for any amount not covered or paid by insurance. If the coverage is through an HMO/PPO in which this office participates, the patient's responsibility is within the guidelines of the contractual agreement. Government issued photo ID required prior to treatment.

Insurance Authorization and Assignment

I hereby authorize Jon T. Ricks, M.D., P.A. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. It is further agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims. When this office agrees to file insurance, it does not assume responsibility for collection thereof.

Signature (Responsible Person) ____________________ Date ____________

PATIENT HISTORY

Today's Date ______________

Name ______________________________ Age __________ DOB ______________ M S D W Sep.
Home Address ______________________________ Zip __________ Phone ______________
Occupation ______________ Employer ______________________ Phone ______________

Husband's Name ______________________________ Occupation ______________
Employer ______________________________ Phone ______________

Menstrual History: First Day Last Menstrual Period ______________ Date of Last Pap Smear ______________
Age at First Period __________ Length of Cycle (Start to Start) __________ Duration __________ Pain __________

Contraceptive History: Current Contraceptive ______________________________
Previous Contraceptives ______________________________

Pregnancies: Total Number ______________

YEAR	LENGTH OF PREG	LENGTH OF LABOR	TYPE OF DELIV	ANESTHESIA	HOSP LOCATION	BIRTH WEIGHT	SEX	COMPLICATIONS

Personal History Usual Weight: __________ **Height:** __________ HAVE YOU AT ANY TIME HAD PROBLEMS WITH

	Yes	No		Yes	No		Yes	No		Yes	No
Head Injury			Veins			Rheumatic Fever			Coughing Blood		
Severe Headache			Stomach			Scarlet Fever			Heart Murmur		
Seizures, Convulsions			Jaundice			Loss of Urine			High Blood Pressure		
Vision			Hepatitis, Mononucleosis			False Teeth			Cancer		
Ear, Nose, Throat			Blood in Stool			Bladder/Kidney Infection			Measles, Mumps, Chicken Pox		
Thyroid			Breast			Pain with Intercourse					
Lung Disease			Female Organs			Excessive Weight Loss					
Shortness of Breath			Syphilis, Gonorrhea			Psychiatric/Mental					
Chest Pain			Easy Bruising			Other					
German Measles			Diabetes			Irregular Menses					

LIST ALL PREVIOUS HOSPITAL ADMISSIONS (except childbirth)

Year	Name of Hospital	Diagnosis	Treatment

HAS ANY MEMBER OF YOUR FAMILY HAD

	Yes	No		Yes	No		Yes	No
Cancer, Leukemia			Diabetes			Epilepsy		
High Blood Pressure			Kidney Disease			Bleeding Tendencies		
Heart Trouble			Tuberculosis			Twins		

Current Medications: ______________________________
Alcohol: Never _____ Moderate _______ Daily _______ Smoking _______ Packages per Day ________
Allergies: ______________________________
Immunizations: dT Booster (q/10 yr) ______________ Hep B Vaccine ______________
Flu Vaccine ______________ Pneumococcal Vaccine ______________

Physician Comments: ______________________________
____
____
____
____

FAMILY HISTORY

	YES	NO
Breast CA	_____	_____
Uterine CA	_____	_____
Cervix CA	_____	_____
Ovarian CA	_____	_____
Colon CA	_____	_____

Jon T. Ricks, M.D., P.A.
OBSTETRICS, GYNECOLOGY, INFERTILITY,
ROBOTIC & PELVIC SURGERY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duty

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. This notice takes effect September 23, 2013 and will remain in effect until we replace it.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us at Jon T. Ricks, M.D., P.A., 5575 Warren Parkway, Suite 316, Frisco, Texas 75034. Telephone 972-377-6800. Fax 972-668-6707.

Uses and disclosures of Medical Information

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

We may use or disclose your protected health information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use or disclose limited amounts of your protected health information to send you fundraising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other than expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

Individual Rights

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions on disclosures that are otherwise allowed. However, in certain instances, if you make a request for restrictions on disclosures, we will be obligated to abide by them. Specifically, if you pay for an item or service in full, out of pocket, and request that we not disclose the information relating to that service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restrictions).

To the extent that this office maintains your Protected Health Information (PHI) in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three (3) years prior to such request, as required by HIPAA and HITECH regulations.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined by HIPAA.