ATHENA FAMILY MEDICINE

8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088 · Phone 469-931-2602 · Fax 469-931-2623

Kevin Vo, MD
Board Certified
Family Medicine

PATIENT REGISTRATION

PATIENT INFORMATION

Last name	First name		M.I.	Previous name (if any)	
Mailing address		Apt #	City	State	ZIP
Home phone	Cell phone		Work phone		
Date of birth	Sex: ☐ Male ☐ Female		Marital status	Social Security # (optional)	
Appointment reminders by: ☐ Phone call ☐ Text message If phone call, which number: ☐ Home ☐ Cell ☐ Work			Employer		
Emergency contact name	Emergency contact phone		Relationship to patient		
Previous doctor (name and city)			Preferred pharmacy (name and location)		

RESPONSIBLE PARTY (GUARANTOR) — if patient is under 18 or someone else pays

Last name	First name	Date of birth	Phone
Address (if different from patient)	City / State / ZIP		Relationship to patient

ADDITIONAL INFORMATION

Email address	May we leave a message about your care and test results? ☐ Yes ☐ No
Race (check all that apply): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Prefer not to answer	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer	**Preferred language:** ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____
How did you hear about us? ☐ Google search ☐ Friend or family ☐ Insurance directory ☐ Another doctor ☐ Online ad ☐ Other: _____	

INSURANCE INFORMATION

PRIMARY insurance company	**SECONDARY** insurance company
Policyholder name and date of birth	Policyholder name and date of birth
Patient relationship to policyholder	Patient relationship to policyholder
Member ID # Group #	Member ID # Group #

Financial responsibility and assignment of benefits. I have read and agree to the Athena Family Medicine (AFM) Office Policy. I understand that I am responsible for payment regardless of insurance coverage. I assign to AFM all insurance benefits I am entitled to for services provided by AFM, not to exceed the amount I owe. I authorize AFM to release medical information to my insurance company or other payer as needed to process my claims. I understand that balances not paid within 90 days of notice may be sent to an outside collection agency.

Medicare beneficiaries. I request that payment of authorized Medicare benefits be made to AFM on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Text and email. If I choose text messages or email, I agree to receive appointment reminders and occasional requests for feedback about my visit. I understand these messages may not be encrypted and I accept that risk. Standard rates may apply. Reply STOP to opt out of texts.

I have received or reviewed Athena Family Medicine's Notice of Privacy Practices. Initials: _____

Signature of patient or responsible party	Printed name	Date
_____	_____	_____

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Name: _____ Date of birth: _____ Today's date: _____

ADULT COMPREHENSIVE HISTORY

Your answers help Dr. Vo get an accurate picture of your health. Please complete all pages. It is long because it is thorough, and we want to know you well so we can care for you properly. If you can't remember details, your best guess is fine. If you are uncomfortable with any question, you may skip it. Thank you!

YOUR VISIT

Who referred you to our practice? ☐ Patient ☐ Family member ☐ Another doctor ☐ Insurance ☐ Online search ☐ Other
Name: _____

Main reason for today's visit _____

Your health goals for the next year _____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Other doctors you see regularly, and their specialty _____

Medical suppliers you use (for example, oxygen or diabetes supplies) _____

MEDICATIONS

List **all** prescription and non-prescription medications, including vitamins, herbs, supplements, birth control, inhalers and over-the-counter pain relievers (Advil, Aleve, Tylenol, etc.). You may also bring your own printed list.

☐ I do not take any prescription or over-the-counter medications.
☐ I brought a list of my medications (give it to the medical assistant).

Medication	Dose (e.g. mg per pill)	How many times per day?

ALLERGIES

Allergies or reactions to medications? ☐ None

If yes, to what, and what happened? _____

IMMUNIZATIONS

Enter the year of your most recent dose, if known.

Tetanus (Td or Tdap) _____ Flu shot _____ COVID-19 _____

Pneumonia (Prevnar or Pneumovax) _____ Shingles (Shingrix) _____ RSV _____

Hepatitis A _____ Hepatitis B _____ MMR _____

Chickenpox (vaccine or had illness) _____ HPV _____ Meningitis _____

Name: _____ Date of birth: _____

SCREENING TESTS

Test	Most recent date	Where	Abnormal?
Cholesterol (lipid panel)			☐ No ☐ Yes
Colon cancer screening: ☐ Colonoscopy ☐ Stool test (e.g. Cologuard) ☐ Sigmoidoscopy Polyps found? ☐ No ☐ Yes			☐ No ☐ Yes
Women: Mammogram			☐ No ☐ Yes
Women: Pap smear / HPV test			☐ No ☐ Yes
Bone density (DEXA)			☐ No ☐ Yes

PERSONAL MEDICAL HISTORY

Do you have now, or have you had in the past, any of these conditions?

Condition	Now	Past
Alcohol or drug use problem	☐	☐
Allergies (hay fever)	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Arthritis (rheumatoid)	☐	☐
Arthritis (osteoarthritis)	☐	☐
Asthma	☐	☐
Bladder or kidney problems	☐	☐
Blood clot (leg)	☐	☐
Blood clot (lung)	☐	☐
Blood transfusion	☐	☐
Breast lump (benign)	☐	☐
Cancer: breast	☐	☐
Cancer: colon	☐	☐
Cancer: ovarian	☐	☐
Cancer: prostate	☐	☐
Cancer: other type	☐	☐
Cataracts	☐	☐
Chickenpox	☐	☐
Colon polyp	☐	☐
Coronary artery disease	☐	☐
Depression	☐	☐
Diabetes (type 1)	☐	☐
Diabetes (type 2)	☐	☐
Diverticulosis	☐	☐
Emphysema / COPD	☐	☐
Fractures (broken bones)	☐	☐
Gallbladder disease	☐	☐
Reflux / heartburn (GERD)	☐	☐
Glaucoma	☐	☐

Condition	Now	Past
Gout	☐	☐
Gynecologic: endometriosis	☐	☐
Gynecologic: fibroids	☐	☐
Gynecologic: other	☐	☐
Heart attack	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Hip fracture	☐	☐
Irritable bowel syndrome	☐	☐
Kidney disease / failure	☐	☐
Kidney stones	☐	☐
Liver disease	☐	☐
Migraine headaches	☐	☐
Osteoporosis	☐	☐
Pneumonia	☐	☐
Prostate enlargement	☐	☐
Seizures / epilepsy	☐	☐
Skin: eczema	☐	☐
Skin: psoriasis	☐	☐
Skin: abnormal moles	☐	☐
Sleep apnea	☐	☐
Stomach ulcer	☐	☐
Stroke	☐	☐
Thyroid nodule	☐	☐
Thyroid: overactive (hyper)	☐	☐
Thyroid: underactive (hypo)	☐	☐

Other conditions or comments (for example, where a fracture was) _____

☐ I have no history of significant medical illness.

Name: _____ Date of birth: _____

SURGERIES AND PROCEDURES

Check any you have had and the year. List abnormal findings or complications under comments.

Procedure	Yes	Year
Abdominal surgery	☐	
Angiogram (heart)	☐	
Angiogram (blood vessels)	☐	
Appendectomy	☐	
Back surgery (lumbar)	☐	
Biopsy (where: _____)	☐	
Breast biopsy: ☐ R ☐ L ☐ Both	☐	
Breast surgery: ☐ R ☐ L ☐ Both	☐	
Cataract surgery	☐	
Colonoscopy	☐	
Coronary bypass	☐	
Coronary stent	☐	
C-section	☐	
Echocardiogram (heart)	☐	
EGD (stomach scope)	☐	

Procedure	Yes	Year
Gallbladder removal	☐	
Heart surgery (other than bypass)	☐	
Hip surgery: ☐ R ☐ L ☐ Both	☐	
Hysterectomy, partial (ovaries left)	☐	
Hysterectomy, total (ovaries removed)	☐	
Knee surgery: ☐ R ☐ L ☐ Both	☐	
LEEP (cervix procedure)	☐	
Neck (spine) surgery	☐	
Ovary removal: ☐ R ☐ L ☐ Both	☐	
Pulmonary function test	☐	
Sinus surgery	☐	
Stress test (any type)	☐	
Tonsillectomy	☐	
Tubal ligation	☐	
Vasectomy	☐	

Other procedures, comments or complications _____

☐ I have never had any surgeries or procedures.

Name: _____ Date of birth: _____

FAMILY HISTORY

Were you adopted? ☐ No ☐ Yes If you were adopted and do not know your family history, skip to the next page.

Check which relatives have had each condition. Parents, brothers and sisters are the most important.

	Mother	Father	Sister(s)	Brother(s)	Mom's mom	Mom's dad	Dad's mom	Dad's dad	Other relative (who?)	Age at diagnosis / cause of death?
Living (✓) or deceased (✗)										
Current age or age at death										
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐		
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐		
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		
Heart attack / angina	☐	☐	☐	☐	☐	☐	☐	☐		
Heart failure (CHF)	☐	☐	☐	☐	☐	☐	☐	☐		
Heart disease, other	☐	☐	☐	☐	☐	☐	☐	☐		
Sudden cardiac death	☐	☐	☐	☐	☐	☐	☐	☐		
Stroke	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes type 1	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes type 2	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: breast	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: colon	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: lung	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: ovarian	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: prostate	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: other	☐	☐	☐	☐	☐	☐	☐	☐		
Colon polyp	☐	☐	☐	☐	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		
Hip fracture	☐	☐	☐	☐	☐	☐	☐	☐		
Depression	☐	☐	☐	☐	☐	☐	☐	☐		
Alcohol or drug use problem	☐	☐	☐	☐	☐	☐	☐	☐		
Alzheimer's / dementia	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Emphysema / COPD	☐	☐	☐	☐	☐	☐	☐	☐		
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐		
Bleeding or clotting disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐		
Macular degeneration	☐	☐	☐	☐	☐	☐	☐	☐		
Hepatitis B or C	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney stones	☐	☐	☐	☐	☐	☐	☐	☐		
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐		

Name: _____ Date of birth: _____

HEALTH HABITS

Tobacco and vaping

Have you ever smoked cigarettes, cigars or a pipe? ☐ Never ☐ Yes

Do you vape or use e-cigarettes? ☐ Never ☐ Former ☐ Current

Other tobacco (snuff, chew)? ☐ Never ☐ Former ☐ Current

Exposure to secondhand smoke? ☐ No ☐ Yes

Current smoker: packs per day _____ for how many years _____

Former smoker: year quit _____ packs per day _____ years smoked _____

Are you ready to quit? ☐ No ☐ Yes ☐ Not applicable

Alcohol

Do you drink alcohol? ☐ No ☐ Yes Drinks per week: _____

How many times in the past year have you had 4 or more drinks (women) or 5 or more drinks (men) in one day? _____

Drug use

Have you ever used recreational drugs? ☐ No ☐ Yes

Which ones? _____

Any used currently? _____

Sexual health

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Partner(s): ☐ Male ☐ Female ☐ Both

Birth control or STI prevention (check all that apply):
☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Implant ☐ Patch ☐ Ring ☐ Shot ☐ Vasectomy ☐ Tubal ligation ☐ Other: _____

Diet and exercise

Do you follow a special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Other: _____

Do you exercise regularly? ☐ No ☐ Yes What kind? _____

Minutes per session _____ Times per week _____

Mood

Over the past 2 weeks, have you often felt down, depressed or hopeless? ☐ No ☐ Yes

Over the past 2 weeks, have you had little interest or pleasure in doing things? ☐ No ☐ Yes

Safety

Do you wear a seatbelt consistently? ☐ Yes ☐ No

Helmet for biking or similar activities? ☐ Yes ☐ No ☐ Not applicable

Working smoke detector at home? ☐ Yes ☐ No

Guns in the home? ☐ No ☐ Yes If yes, locked with ammunition stored separately? ☐ Yes ☐ No

Has anyone hurt, threatened or frightened you, or are you afraid of someone at home? ☐ No ☐ Yes

Other

Military service? ☐ No ☐ Yes

Exposure to toxic chemicals at work or in hobbies? ☐ No ☐ Yes

Name: _____ Date of birth: _____

ABOUT YOU

Name you prefer we use _____ Country of birth _____

Who lives with you? ☐ No one ☐ Spouse or partner ☐ Children ☐ Parents ☐ Roommates ☐ Other: _____

Occupation (or prior occupation) _____ Employer _____

If not currently working: ☐ Retired ☐ Unemployed ☐ On leave ☐ Disabled ☐ Homemaker ☐ Student ☐ Other

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed

Number of children _____ Ages of minor children _____ Grandchildren _____

Education: ☐ High school or GED ☐ Trade school ☐ College ☐ Graduate school ☐ Other

Interests, hobbies, or travel outside the country in the past 6 months _____

_____

ADVANCE CARE PLANNING

Check any of these Texas documents you have completed:

☐ Directive to Physicians (living will)
☐ Medical Power of Attorney
☐ Out-of-Hospital Do-Not-Resuscitate (DNR) order
☐ I know about these but have not completed them
☐ I would like information about these

WOMEN'S HEALTH

Total pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Age when periods started _____ Age when periods ended (menopause or hysterectomy) _____

☐ Not applicable

If you have periods: every _____ days, lasting _____ days. Any concerns about periods or menopause? ☐ No ☐ Yes

Thank you for taking the time to complete this form!

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HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from my insurance company or other payers.
- Conduct normal health care operations, such as quality assessments and physician certifications.

I have been informed of Athena Family Medicine's *Notice of Privacy Practices*, which describes how my health information may be used and disclosed. The Notice is available in print at the office and on the clinic website. I have had the opportunity to review it before signing this consent. I understand that Athena Family Medicine may change its Notice of Privacy Practices from time to time, and that I may request a current copy at any time.

I understand that I may request in writing that Athena Family Medicine restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the practice is not required to agree to my requested restrictions, but if it does agree, it is bound to follow them.

I understand that I may revoke this consent in writing at any time, except to the extent that Athena Family Medicine has already taken action relying on it.

Patient name (printed) _____ Date of birth _____

Name of representative, if signing for the patient _____ Relationship to patient _____

_____ _____
Signature of patient or representative Date

_____ _____
Witness signature Date

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CONSENT FOR TREATMENT

I, _____, authorize and direct the physician and staff of Athena Family Medicine to provide medical care that is determined to be necessary at the time of service.

_____ _____
Patient signature Date

_____ _____
Witness signature Date

If the patient is a minor or unable to sign

_____ _____
Name of person giving consent (printed) Relationship to patient

_____ _____
Signature of person giving consent Date

CONSENT TO DISCUSS MEDICAL INFORMATION

I, _____, give the physician and staff of Athena Family Medicine permission to discuss my health history, condition and treatment with the people listed below.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

☐ **No one.** Please do not discuss my medical information with anyone else.

_____ _____
Patient signature Date

_____ _____
Witness signature Date

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OFFICE POLICY

Thank you for choosing Athena Family Medicine as your primary care provider. This policy explains how our office works, so you know what to expect.

Office hours. Our clinic is open Monday through Friday, 8:00 am to 5:00 pm, and closed Saturday and Sunday. We are closed daily from 12:00 to 1:00 pm for lunch. We have one location: 8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088.

Ages. We see patients age 5 and older.

Appointments. We see patients by appointment and as walk-ins, Monday through Friday, 8:00 am to 5:00 pm (closed 12:00 to 1:00 pm for lunch). Same-day appointments and walk-ins are usually available for urgent or sudden illness, and may require some waiting time.

Emergencies. For a medical emergency, call 911 right away.

Urgent needs or sudden illness. We have a limited number of same-day ("work-in") appointments every day. Please call early in the day, because these spots fill quickly. If no same-day appointment is available, the receptionist will offer another day or transfer you to the medical assistant, who will discuss your needs with the physician and let you know what to do.

Cancellations. Please call at least 24 hours ahead if you cannot keep your appointment. There is a $25 fee for missed appointments, so please let us know if you can't make it. This allows us to offer the time to another patient. See our Cancellation and No-Show Policy.

Wait times. We know your time is valuable. If you have waited more than 15 minutes, please let the front desk know so we can check on the physician's schedule and make sure you were checked in properly.

Treatment of minors. Patients under 18 must be accompanied by a parent or legal guardian, or bring written permission for treatment from a parent or guardian along with a copy of the parent's or guardian's driver's license. The new patient forms for children, including the consent for treatment, can be downloaded from our website.

Narcotics. We do not prescribe narcotic pain medications. Patients who need narcotics will be referred to a pain management specialist.

Mental health. We routinely treat mild depression, anxiety and insomnia. We do **not** treat moderate to severe chronic mental health conditions, and we do **not** treat mental health conditions in children. These patients will be referred to a psychiatrist based on the severity of their condition. Patients taking psychiatric medications must be seen in our office **every three months** for assessment and refills, and a urine drug screen will be required ($45, self-pay).

Weight management. Patients seeking weight management must first have a complete physical exam, including an EKG and blood work. Patients who are candidates for weight loss medication must be seen in our clinic **monthly** for assessment and refills. Our weight loss management program is strictly self-pay. We do not bill insurance for these visits.

Lab work. Lab work and blood draws are done by outside lab facilities, such as Labcorp or Quest Diagnostics, and are billed to your insurance. Self-pay patients may choose the lab of their choice.

Labs ordered by other doctors. We do not routinely draw lab work ordered by other physicians, but we will do so if you are here for an appointment. If another physician wants blood tests but cannot draw them in their office, please ask that physician for a lab order to take to the lab of your choice.

Lab fees. All lab services are billed by the outside lab facility. If you have questions about a lab bill, please contact the lab's billing department first. We do not have access to their billing information.

Physical exams. We believe routine annual physical exams with screening lab tests are very important for maintaining good health. However, insurance benefits vary. Some plans cover "wellness" visits, while others only cover visits for a specific problem. Please learn about your insurance benefits before your appointment so you know what your plan covers.

Test results. If you have diagnostic testing, such as labs, x-rays, an EKG, an ultrasound or a sleep study, your doctor will review the results, typically within 7 to 10 days, and decide whether you need a follow-up appointment. Our clinic will contact

you with your results and let you know if an appointment is needed.

Patient portal. We encourage all patients to register for our online patient portal, where you can view your medical records, including test and lab results. You can find the portal link on our website, www.athenafamilymedicine.com.

Prescriptions and refills.

- The best time to request a refill is during your appointment.
- We do not refill antibiotics. Patients who need more antibiotics must be seen by the physician.
- If you call for a refill, please don't wait until you run out. Most refills need the doctor's approval, so please allow 2 to 3 days.
- Some medications have side effects that must be monitored. We require check-ups every 3 to 6 months for these medications, so please keep your follow-up appointments.
- Please do not call after hours for refills.

Referrals. Referrals can sometimes be completed the same day as your appointment, and sometimes take 7 to 10 days, depending on your insurance and the urgency of your situation. We will contact you as soon as the referral authorization is obtained. It can sometimes take a few weeks to get an appointment with a specialist, depending on the specialist's schedule.

Dismissal from the practice. Being dismissed means you can no longer schedule appointments, get refills, or consider us your doctor. Common reasons for dismissal include: repeatedly missing or rescheduling appointments; not following the physician's instructions about an important health issue; abusive behavior toward staff or other patients; and failure to pay your balance. If you are dismissed, we will send a letter to your last known address. If you have a medical emergency within 30 days of the date of that letter, we will see you. After that, you will need to find another physician. We will forward a copy of your medical record to your new doctor once you tell us who it is and sign a release form.

Self-pay. Self-pay is available for patients without insurance. Payment is due at the time of service. If you cannot pay your balance in full, please make arrangements with our staff in advance.

Insurance. We are contracted with several insurance companies, but it is your responsibility to confirm that our physician is in network with your plan and to know your insurance benefits. We need your complete demographic and insurance information before your appointment, and we will ask you to update it about every six months. Please bring your insurance card and a photo ID to every appointment, along with any other forms that will help us file your claim correctly and on time.

Accepted insurance. We accept most commercial insurance plans, Medicare and certain supplemental plans. We do **not** accept Molina, Medicaid or Amerigroup. Coverage changes often, so please call to confirm before your visit.

Fees and copays. At the time of service, you are responsible for all charges not covered by your insurance, including copays, coinsurance, deductibles and non-covered services. We cannot waive copays, because they are required by your insurance company. We try to calculate your share as accurately as possible, but with so many differences between plans, our estimate may not be exact. You may receive a statement from our office for any remaining balance.

Auto accidents. We do **not** see patients for injuries related to automobile accidents.

Workers' compensation. If you were injured at work, please tell the receptionist right away. We are not authorized to treat workers' compensation injuries. Please contact your supervisor for instructions on filing a workers' compensation claim.

Disability and FMLA. We do **not** perform disability assessments, and we do **not** complete FMLA, long-term disability or short-term disability paperwork.

Home health and nursing facility care. Patients who need home health or nursing facility care must first be seen by our physician for a face-to-face evaluation. A referral to a home health agency can be made at that visit.

Medical equipment (DME). Patients who need durable medical equipment or orthotics must first be seen by our physician for an evaluation, and specific orders will be written at that visit.

Letters of medical necessity. If you need a letter of medical necessity, please discuss the details with the physician so the letter is completed correctly. Allow 7 to 10 business days for the letter, and tell the medical assistant who the letter should be addressed to.

In-office procedures. Our physician does not perform in-office procedures.

Corticosteroid injections. Our physician performs corticosteroid joint injections and trigger point injections for pain. A procedure consent form is required.

Hospital or ER follow-up. Please tell us when scheduling if your appointment is a follow-up after a hospital stay or emergency room visit. Bring all related documents, such as lab results, x-ray and MRI reports, your discharge summary, and the name of the hospital and date you were seen.

Medical records. We will provide a copy of your medical records on request. A signed release form is required before records can be copied. Please allow up to 30 days for your request to be processed.

X-rays and imaging. You can request copies of x-rays and other imaging directly from the imaging center. The imaging center may require you to sign its own release form.

Collections. Accounts not paid within 30 days will begin our in-house collection process. If your balance is 65 days old, your doctor will be notified and you may be dismissed from the practice.

Billing. If you receive a bill from us, please contact your insurance company first. If you have questions about your bill, please call us right away. If you cannot pay your entire balance, please call to set up a payment arrangement.

Thank you for choosing Athena Family Medicine as your primary care provider.

Acknowledgment

I acknowledge that I have received and read the Athena Family Medicine Office Policy, including its financial policies.

Patient name (printed) _____ Date of birth _____

_____ _____

Signature of patient or guardian Date

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CANCELLATION AND NO-SHOW POLICY

We have a waiting list for new patients as well as a full schedule of ongoing patient appointments. Out of respect for our staff and for patients waiting for an appointment, we ask for your help in keeping last-minute cancellations to a minimum. This policy has been in effect since November 1, 2019.

Cancellations

Please give us at least 24 hours' notice if you need to cancel or reschedule your appointment. If you do not notify us in advance, a $25 fee will be charged and is payable at your next appointment. We understand that emergencies happen, and we will decide on a case-by-case basis whether the fee will be waived.

No-shows

A $25 fee will be charged for each missed appointment. This fee cannot be billed to your insurance and is due at the time of your next appointment.

Thank you for helping us keep our schedule running smoothly, and thank you for choosing Athena Family Medicine as your primary care provider.

Acknowledgment

I acknowledge that I have received and read the Athena Family Medicine Cancellation and No-Show Policy.

Patient name (printed) _____ Date of birth _____

_____ _____

Signature of patient or guardian Date

ATHENA FAMILY MEDICINE

8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088 · Phone 469-931-2602 · Fax 469-931-2623

Kevin Vo, MD
Board Certified
Family Medicine

AUTHORIZATION TO RELEASE HEALTH INFORMATION

TO Athena Family Medicine

Please complete the entire form.

I authorize (name of doctor or facility that has the records) _____

Their phone _____ Their fax _____

to release health records for:

Patient name _____ Date of birth _____ Last 4 of SSN _____

Primary phone _____ Other phone _____

Records to release: ☐ All records ☐ Office visit notes ☐ Lab results ☐ Imaging reports ☐ Immunizations
☐ Other: _____

Covering dates from _____ to _____

☐ or all dates

Purpose of release _____

For example: continuing care with a new doctor.

Please send records to:
Kevin Vo, MD / Athena Family Medicine
8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088
Phone 469-931-2602 · Fax 469-931-2623

I understand that the information in my health record may include information about sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.

☐ **Yes**, I consent to the release of this information. ☐ **No**, I do not consent to the release of this information.

Revocation: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Expiration: Unless I write a different date or event here: _____, this authorization expires 90 days from the date of my signature.

Re-disclosure: I understand that information released under this authorization may be re-disclosed by the person or facility receiving it and may no longer be protected by federal privacy law.

Medical care is not conditional on signing this authorization. The physician and employees are released from legal responsibility or liability for disclosing the above information to the extent indicated and authorized here.

_____ _____ _____
Signature of patient or legal representative | Relationship to patient | Date