P. DOUGLAS
COCHRAN, MD LTD.
FAMILY MEDICINE

Phone: **(432) 699.6000**
Fax: (432) 699.6012
Board Certified in Family Practice

Dear Valued Patients,

We want to thank you for choosing P. Douglas Cochran, MD LTD as your partner in healthcare. We look forward to a long term relationship with you and your family.

In the midst of all the changes in healthcare, unfortunately we have seen many adverse effects on our clinic. In order for our practice to continue to provide the best level of care and service to our patients, we have no choice but to implement an annual fee for the ever increasing services not covered by insurance. This includes but are not limited to referrals, medication refills, prior authorizations, insurance issues, and the increased phone work. We have evaluated many options and this is the best choice for our practice.

This annual fee will go into effect June 1, 2016. All payments are due no later than July 1, 2016.

P. Douglas Cochran, MD LTD Non-Covered Fee for 2016:

1 Patient: $115.00 per year

2 Patients: $220.00 per year (for spouses/parents or a child 18 and under living in same house)

3 Family Members: $300.00 (for spouses/parents or a child 18 and under living in same house)

4 or More Family Members: $360.00 (for parents and children 18 and under living in same house)

Please know that we want to keep this affordable for our patients, while being able to remain open for business to provide quality healthcare.

If you are a new patient and do not know the level of care we provide, please give us time to show you how much our practice individualizes the services we offer. We go above and beyond for our patients, within the legal limits, and do everything we can to make you feel valued as we team up with you in treating your healthcare needs.

If you choose to seek care from another provider, do not follow our protocols, or are dismissed from our practice by Dr. Cochran, unfortunately there will be no refund given.

We thank you for your understanding and commit to continue to provide the best level of care to our valued patients.

Patient Signature: _____

P. Douglas
COCHRAN, MD LTD.
FAMILY MEDICINE

4214 Andrews Highway · MMH West Campus, Suite 306 · Midland, Texas 79703
www.drcochranmd.com
432-699-6000

Account (Patient ID) #_____

NOTE: EACH FAMILY MEMBER MUST SUBMIT A SEPARATE FORM

General Patient Information

Patient's Full Legal Name: _____ ❑ Male ❑ Female

Address: _____City_____State_____Zip Code_____

Contact Phone #'s (check preferred):

❑ Home_____❑ Work _____ ❑ Mobile_____ ❑ OK to Text?

Email Address: _____ Pharmacy: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Employer Address: _____

Spouse's Name: _____

Emergency Contact Person_____ Relation?_____ Phone #: _____

Other Family Members Treated in this office: _____

Who referred you to our offices? _____

IF PATIENT IS A "MINOR"...

Parent's Full Legal Name: _____

Patient Insurance Information

A valid driver's license or ID card must be presented with your insurance card for scanning and verification.

PRIMARY Insurance Co. _____ID #: _____Policy #_____Group #_____

Name of Insured: _____SS#_____ DOB: _____

Relationship to Patient:_____

SECONDARY Insurance Co. _____ID #: _____Policy #_____Group #_____

Name of Insured: _____SS#_____ DOB: _____

Relationship to Patient:_____

The patient or responsible party must inform us immediately of any changes in insurance plans or coverage benefits.

STATEMENT OF FINANCIAL RESPONSIBILITY

PRINT FULL LEGAL PATIENT NAME _____

1. PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct payment of my medical benefits to the offices of P. Douglas Cochran, M.D, LTD for any services furnished to me by the physician(s) or offices. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical services to third party payers and/or health practitioners. I agree to inform the offices of P. Douglas Cochran, M.D., LTD. immediately of any changes in my insurance plans or coverage benefits. In the event that my health plan determines a service to be "not covered," I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

_____ _____

Signature of Patient (or Responsible Party) Date

2. PAYMENT

I hereby assume responsibility to pay the costs of all services provided by the offices of P. Douglas Cochran, M.D, LTD. to the patient.

_____ _____

Signature of Patient (or Responsible Party) Date

3. AUTHORIZATION OF PAYMENTS

I understand that P. Douglas Cochran, M.D., LTD. will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to P. Douglas Cochran, M.D., LTD. and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance and non-covered services.

_____ _____

Signature of Patient (or Responsible Party) Date

4. LABORATORY BILLS

I understand the outside reference laboratory will bill me directly for all laboratory tests performed by the company. I understand that fee schedule (cost) for laboratory tests performed by P. Douglas Cochran, M.D., LTD. shall be available to the patient upon request.

_____ _____

Signature of Patient (or Responsible Party) Date

5. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

I have been informed and understand that P. Douglas Cochran, M.D., LTD. employs Physician Assistants and Nurse Practitioners. A Physician Assistant (PA) or Nurse Practioner (NP) is a medical professional who works as part of a team with a doctor. I understand that a PA is a graduate of an accredited PA educational program who is nationally certified and state-licensed to practice medicine with the supervision of a physician, and that an NP is a graduate of a master's or doctoral degree program and has advanced clinical training beyond their initial profession registered nurse preparation to practice medicine with the supervision of a physician. I hereby authorized that a PA and/or NP, under the supervision of the attending physician, may render my medical care jointly. I understand that there may be appointments that require me to see primarily the PA or NP without prior notice. I authorize the PA and/or NP to communicate my diagnosis and treatment with his or her supervising attending physician, as well as, with other health care practitioners involved in my case. I authorize the admittance of qualified observers, including medical students, during my consultation and examination unless I specifically state otherwise at the time of exam.

_____ _____

Signature of Patient (or Responsible Party) Date

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have read and understand P. Douglas Cochran, M.D., LTD.'s Notice of Privacy Practices in accordance with HIPPA rules and regulations, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

_____ _____ _____

Printed name of patient | Signature of patient or representative / Guardian | Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

Patient Office Policies

Visit our website at www.DrCochranMD.com for a complete and updated list of policies and information.

Payment Terms:

Co-Payment and deductibles are due in full immediately at the time of service. No "payment plans" are offered unless previously agreed upon between the patient and the offices of P. Douglas Cochran, M.D., LTD. There will be a $50.00 service charge for any payment with non-sufficient funds. This fee, in addition to the original outstanding charge, must be paid immediately, or the case will be handed over to the District Attorney's office. Payment of any outstanding balance must be paid prior to any future patient services.

No-shows and Missed Appointments:

Unexplained or unreasonable no-shows or missed appointments will not be acceptable. Patients are considered a no-show if they miss their appointment without a 24 hour notice or if they arrive later than 15 minutes for their scheduled appointment. If the patient wishes to be rescheduled, there will be a $50 rescheduling fee for each 15 minutes increment the patient was originally scheduled. This fee must be paid prior to being rescheduled.

Record Reproduction Terms:

Request for reproduction of medical records for legal, insurance, or private use will incur a service fee of $50.00 for the first 25 pages and $0.25 per page thereafter.

Additional Provider Paperwork Terms:

Requests for additional paperwork such as letters, form completion, or supplemental insurance paperwork will incur a service fee of $50.00 per activity if the medical team deems it appropriate.

Patient Behavior and Interaction Terms:

Abusive, violent, threatening, or unruly treatment toward any member of the staff or other patients will not be tolerated and will be reported to the Midland Police Department and prosecuted to the full extent of the law. Dishonest behavior will not be tolerated. Patients who are non-compliant with their medical care will not be tolerated. Patients who take part in such behavior will be terminated from the offices of P. Douglas Cochran, M.D., LTD. immediately. Dr. Cochran reserves the right to terminate the physician-patient relationship for any other reason. If termination or dismissal from the practice takes place, a reasonable time period will be provided in order to allow the patient to establish care with another physician.

Phone Calls and Requests:

Patients must allow 48 hours for refill requests or non-urgent phone call returns.

Minor Patients Terms:

Patients under 18 years of age are to be accompanied by an adult retaining legal guardianship or legal aid representation. Non-parental relationships are expected to present signed consent statements from their parents or their legal documentation expressing rights of guardianship or legal aid verification.

Service Restriction Terms:

Patients will be seen by appointment only. The offices of P. Douglas Cochran, M.D., LTD. will not participate or testify in insurance or law-suit cases, Workman's Compensation cases, or Disability exams. Dr. Cochran does not admit to or see patients in the hospital. Patients requiring acute admission to the hospital will be attended by the hospitalist on call. Patients who require chronic inpatient care, nursing home care, or who cannot be brought to the clinic for regular visits, will need to seek an alternative provider. Non-English speaking patients should make an effort to be accompanied by a translator; however, a telephone translator service will be available unless there is a phone line malfunction at the time of appointment. Except for parents of minors, only one visitor may accompany each patient in the exam room unless the medical team deems it inappropriate or hindering of care.

Controlled Substance Prescription Terms:

Patients that require a controlled substance prescription, have received and agreed to abide by the controlled substance policy and all fees that apply.

By signing below, I hereby certify that the information I have furnished on these forms is complete, true, and accurate. I have carefully read and understand all of the terms above:

Patient/Legal Guardian Signature _____ Date _____

Controlled Substances Policy Updated March 4, 2019

Controlled substances include but are not limited to:

Narcotics (hydrocodone, norco, vicoden, vicoprofen, etc.)
Stimulants (most types of ADD/ADHD meds, certain weight loss medications, etc.)
Benzodiazepines (Xanax, klonopin, valium, etc.)
Hypnotics (ambien, etc.)
Hormones (testosterone or hormone replacement, etc.)

The following policy remains enforced due to concern for the safety of our patients, the countrywide worsening of the abuse of controlled substances and more stringent recommendations, demands, and repercussions from the Texas Medical Board.

Our offices will not refill narcotics without an office visit. However, an office visit does not guarantee that a refill will be given. If the patient cannot comply with this schedule we will be happy to try and refer you to pain management but cannot guarantee the patient will receive an appointment.

In addition, no controlled substances whatsoever will be refilled or given without an initial visit addressing the specific problem and an appointment at least every 3 months. Additionally, our office is required by certain insurance companies for patient on controlled substances to have a face-to-face nurse appointment every month. Any controlled substance prescription given without an appointment incurs a $10.00 patient fee. No exceptions will be made. Follow up appointments should be made at the time of the patient's current appointment to avoid problems.

In addition, refills of narcotics will be limited to 30 days of medication per prescription. Other controlled substances possibly may be written for 90 days per prescription, per the provider's discretion, if the patient has a proven history of compliance and prior insurance approval.

All patients taking controlled narcotics, stimulants, benzodiazepines, or requesting to start such medications, will be lab tested for compliance on most if not every scheduled visit in which a refill is requested. We reserve the right to test at random prior to prescription refills. If a patient is discovered using any illegal substances (marijuana, cocaine, heroin, and other illegal substances) while being treated with a controlled medication it will result in the termination of controlled substance prescriptions and is grounds for potential dismissal from the practice.

Patients who have been referred to or already see a specialist or another physician who deals with specific controlled substances will not be prescribed those medications by this office. This includes Pain Doctors, Orthopedists, or Psychiatrists. In the event that the patient chooses to stop that relationship or is dismissed by that practice, it will be the patient's responsibility to find another specialist from whom he/she can continue care.

Any patient non-compliant with this policy will no longer be issued these drugs and may be dismissed from the practice immediately if dishonestly is displayed.

We apologize for inconveniences that result from this policy. It does not necessarily represent issues with our specific practice and valued patients, but a change in standard of care and increased demands for monitoring of these potentially dangerous drugs.

P. Douglas Cochran, MD

_____ _____ _____

Signature of Patient (or Responsible Party) Printed Name Date

Patient Medical History

Previous Physician's name: _____

Date of last exam: _____

Which of the following conditions are you currently being treated or have been treated for in the past?

(please check and explain details if needed)

- ❑ Coronary Artery disease / blockage_____
- ❑ Congestive Heart Disease_____
- ❑ Stroke_____
- ❑ Diabetes_____
- ❑ Cancer_____
- ❑ High Blood Pressure_____
- ❑ High Cholesterol _____
- ❑ Asthma _____
- ❑ Seizures _____
- ❑ Kidney / Bladder problems _____
- ❑ Eye disorder / Glaucoma _____
- ❑ Chronic Lung problems / COPD/ Emphysema _____
- ❑ Stroke _____
- ❑ Liver problems / Hepatitis _____
- ❑ Low blood pressure _____
- ❑ Headaches / Migraines _____
- ❑ Arthritis _____
- ❑ Heartburn / Reflux / GERD_____
- ❑ Seasonal or Perennial allergies _____
- ❑ Neurological problems _____
- ❑ Anemia or blood problems _____
- ❑ Depression / Anxiety _____
- ❑ Bipolar Disorder or Schizophrenia _____
- ❑ Peptic Ulcers/ Colitis_____
- ❑ Irritable Bowel Syndrome_____
- ❑ Swollen ankles _____
- ❑ Chronic Ear, Sinus, or Tonsillar problems _____
- ❑ Thyroid problems _____
- ❑ STD's or other communicable diseases_____
- ❑ Autoimmune diseases / rheumatoid / lupus fibromyalgia _____

Please describe any current or past medical treatment not listed above...

_____

(continued)

_____

_____

Have you ever been hospitalized? ❑ No ❑ Yes (If yes, what for?) _____

Past Surgeries:_____

_____

Allergies:

Are you allergic to any drugs? ❑ No ❑ Yes (If yes, please list...) _____

_____

Current Medications: *(give name of drug, dose, how often taken)*

Please list...

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Drug Name:_____ _____mg(s) _____ # of times/day

Others:

_____

_____

Social History:

Marital Status: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed

Sexual Orientation: ❑ heterosexual ❑ homosexual ❑ bisexual

Alcohol Use: ❑ never ❑ rarely ❑ moderate or daily (7-14 drinks/week) ❑ heavy (more than 14 drinks/week)

Tobacco Use: ❑ never ❑ dip snuff ❑ chew ❑ previously, but quit (date)_____ ❑ Current, pack/day____

Illicit Drugs: ❑ never ❑ previously, but quit (date)_____ type?_____ ❑ Current, type_____

Family History:

List serious illnesses or diseases (including heart disease, diabetes, high blood pressure, high cholesterol, cancer, stroke, depression, autoimmune deseases, etc.)

Father ❑ living ❑ deceased, age at death _____ Problems _____

Mother ❑ living ❑ deceased, age at death _____ Problems _____

Sibling ❑ living ❑ deceased, age at death _____ Problems _____

Sibling ❑ living ❑ deceased, age at death _____ Problems _____

Sibling ❑ living ❑ deceased, age at death _____ Problems _____

Sibling ❑ living ❑ deceased, age at death _____ Problems _____

Screening and Diagnostic Tests

Date of last colonoscopy?_____ Findings?_____

Date of last Exercise Tolerance Test (Treadmill Stress Test)?_____ Findings?_____

Males:

Date of last prostate exam?_____ Findings?_____

Date of last PSA (prostate blood test)?_____ Findings?_____

Females: (Gynecological History)

How many times have you been pregnant? _____

Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ❑ Yes ❑ No Diagnosis: _____ Follow up: _____

Date of last mammogram: _____ Findings?_____

Have you ever had a breast biopsy? ❑ Yes ❑ No Biopsy results: _____

Immunization History

Are childhood immunizations complete or up to date for age? ❑ yes, If not, explain_____

Date vaccinated against pneumococcal illnesses (the “pneumonia shot”)? _____

Date vaccinated against meningococcal illnesses (the “meningitis shot”)? _____

Date vaccinated against HPV infections (the “cervical cancer vaccine”)? _____

Date of last tetanus vaccination? _____

Date of last influenza vaccination (the “flu shot”)? _____

Have you been vaccinated for hepatitis B? ❑ Yes ❑ No If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? ❑ Yes ❑ No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ❑ Positive ❑ Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ❑ Positive ❑ Negative

Have you had a sexually transmitted disease including HIV or viral hepatitis? ❑ Yes ❑ No - Diagnosis: _____

Additional Information:

Any additional information you believe our offices should know:_____

_____

_____

_____

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on these forms is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____

Account (Patient ID) # _____

Consent to Communicate

Dr. Cochran & Staff has my permission to contact me via:
(please check all that apply)

Method	Preferred	Phone #	OK to leave **detailed** message on voicemail (Including test results & recommendations)	OK to leave **basic** message on voicemail ("This is Dr. Cochran's office please return our call")
Cell Phone	☐		☐ YES ☐ NO	☐ YES ☐ NO
Work Phone	☐		☐ YES ☐ NO	☐ YES ☐ NO
Home Phone	☐		☐ YES ☐ NO	☐ YES ☐ NO
Mail Letter if Normal Labs	☐	Address:		

_____ _____ _____
Printed name of patient | Signature of patient or representative/guardian | Date

Permission to Share Health Information with Family/Friends

By signing below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require HIPAA compliant authorization.
This premission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of individual & Relationship to patient	Comments/Instructions (i.e. may pick up meds, may disclose test results, etc.)	Patient/Guardian Initials

_____ _____ _____
Printed name of patient | Signature of patient or representative/guardian | Date

Please Note as of January 1st, 2016

Due to the change in many insurance policies, the beginning of a new calendar year, and the time that it takes the staff to work on prescription authorization requests,

We are requiring you to present a current insurance card at <u>EVERY</u> visit.

Failure to do this will result in rescheduling of your appointment.

Thanks for your understanding,

P. Douglas Cochran, MD
Kara Cochran, Practice Manager
And Staff

Patient Initials _____

AUTHORIZATION OF MEDICAL INFORMATION RELEASE FORM

P. DOUGLAS COCHRAN, MD, LTD

4214 Andrews Hwy – Suite 306

Midland, Texas 79703

Office # 432-699-6000 Fax # 432-699-6012

I hereby authorize release of information from the medical record(s) of:

Patient Name:_____ **Date of Birth:**_____

Social Security #:_____ Phone #:_____

Release to:

Dr. P. Douglas Cochran

4214 Andrews Hwy – Suite 306

Midland, Texas 79703

Fax # 432-699-6012

From:

_____

_____

_____

FAX #_____

Please release the following:

___Problem List ___Progress Notes ___History/Physical

___Lab Reports ___Immunizations ___X-ray Reports

___CT/MRI Reports ___X-ray Films

___Other Diagnostic Reports (specify)_____

I understand that the information released is for the purpose stated above. Any other use of this information without the written consent of the patient is prohibited. This consent will expire 365 days after the date of my signature, unless otherwise specified.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness