cope center for colorectal & pelvic health

Clifton L. Cox, M.D.

Welcome Back!

Many things have changed, and some have remained the same…
On behalf of Dr. Clifton L. Cox, we welcome you back to our practice. Since we have last seen you, many things have changed, but some have remained the same. We remain committed to our mission:

> ***We strive to provide compassionate, personalized, evidence-based treatment to maximize your colorectal and pelvic floor health.***

We are excited about the many changes to our practice, and look forward to hearing your comments on them. We are very proud of our **new facility**, which has been built expressly for the needs of our patients. For most, it is easier to get to, and the design is the culmination of 18 years experience in providing specialized care to colorectal and pelvic floor patients.

We have **renamed the practice** to reflect the broader scope of services we provide. We are now the **COPE Center for Colorectal and Pelvic Health**, which reflects both the **CO**-lorectal and **PE**-lvic health aspects of our clinic. We can now provide under one roof a full range of diagnostic and treatment options to patients, including pelvic floor physical therapy, non-operative treatment of anorectal conditions, and more complex colon and pelvic floor surgical procedures. We will continue to do all outpatient surgery at Baylor Surgicare - Grapevine and the beautiful new private facility, Forest Park Medical Center in Southlake. We also perform more complex inpatient surgeries at Forest Park Medical Center as well as Baylor Regional Medical Center – Grapevine.

In order to make your time in the office as efficient as possible, we have enclosed a set of patient forms for you to update. Not only do these forms fulfill the regulatory requirements required to see you, they provide important clinical information that will optimize your care. We hope that by completing these forms in the comfort and privacy of your own home, you will take the time to answer as honestly and thoroughly as possible. Please bring the completed packet at least 10 minutes prior to your appointment, along with proof of insurance, a photo ID, a list of all the medications you are taking and any other information you feel may be pertinent.

Cancellation or Rescheduling Appointments
We are generally booked well in advance for all patient appointments. Please check all calendars to be sure your appointment date and time work. We ask that you notify us 24 hours in advance to cancel or reschedule an appointment. This will enable us to schedule someone else in that valuable time spot.

Directions
Our office is located at 300 S. Nolen Drive Suite 100 in Southlake, TX.
From Hwy 114, Exit Kimball Avenue and turn South. Go to the next intersection, Southlake Blvd (FM 1709), and turn East (left) then turn South (right) at S. Nolen Dr. (Starbucks is on the corner). We are on the right hand side of the street.

On Mapquest, you can find us at: http://mapq.st/1j0JXhr.

On Google Maps the link is: http://goo.gl/maps/Pm5br

We look forward to seeing you soon!

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Patient Information Sheet

Personal Information

Last Name:	First:	MI:	Date:
Name you wish to be called/nickname:		Social Security #:	
Drivers License # and State:	Date of Birth:	Gender: Male Female	
Home Address:			
Mailing Address (if different) :		Email Address:	
Please circle your current marital status: Single Married Divorced Widowed Separated			
Employment status: Full-time Part-time Not Employed Self Employed Retired Active Duty Military			
Employer Name:	Student Status: Full-Time Part-Time Not A Student		
Employer's Address:			
Spouse/Partner's Name:	Birthdate:	Work #:	

Telephone Preferences

Home:	Work: Ext:	Cell:
In the event of an emergency, who should we contact? Name:		
Relationship:	Home #:	Work #:

Health Insurance

Primary Insurance Co. Name:		Customer Service #:
Member/Subscriber ID#:	Group/Account/Plan#:	
Claims mailing address:		
Name of Policyholder:	Policyholder's relationship to patient:	
Policyholder's address (if different):		
Policyholder's social security #:		Policyholder's date of birth:
Is insurance coverage obtained through an employer? YES NO		Policyholder's employer:
Secondary Insurance Co. Name:		Customer Service #:
Member/Subscriber ID#:	Group/Account/Plan#:	
Claims mailing address:		
Name of Policyholder:	Policyholder's relationship to patient:	
Policyholder's address (if different):		
Policyholder's social security #:		Policyholder's date of birth:
Is insurance coverage obtained through an employer? YES NO		Policyholder's employer:
Additional Insurance Co. Name:		Member ID#:
Group/Account/Plan #:	Name of Insured:	Relationship:
Claims mailing address:		

Referrals

PCP/Family Physician:	City:	Phone #:
Referring Physician:	City:	Phone #:
Additional Physician:	City:	Phone #:
Pharmacy:	Phone #:	Cross streets:
How did you hear about us?		

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

Previous Illnesses
Please list all illnesses you have had and their dates:

_____

_____

Previous Colon Screening
Please list the most recent colon screenings you have undergone and their dates:
Flexible Sigmoidoscopy: _____ Barium Enema: _____
Colonoscopy: _____

Past Surgical History
Please list all operations you have had and their dates:

_____

_____

Medications:
Please list al medications that you are currently taking and their doses, including aspirin and any over-the-counter or herbal medications.

_____

_____

_____

Allergies:
Please list all medication you are allergic to and your reaction to the medication
☐ No known drug allergies _____

_____

Family History of Colon or Rectal Cancer/Polyps
Please list family member and disease:

_____

_____

Review of Systems
Do you currently have or have ever had, problems with any of the following?
Please check all that apply. If you do not check the box, we assume the answer is no.

General
- ☐ Recurrent fever
- ☐ Significant weight change

Eye, Ear, Nose & Throat
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinopathy
- ☐ Sinus problems
- ☐ Dental problems
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Recent sore throat
- ☐ Difficulty swallowing

Urologic
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary incontinence

Hematologic
- ☐ Anemia
- ☐ Blood disorder

Dermatologic
- ☐ Rash
- ☐ Skin Cancer

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart murmur
- ☐ Abnormal heart valve
- ☐ Heart attack
- ☐ Swollen feet
- ☐ Abnormal stress test
- ☐ Pacemaker
- ☐ Use of blood thinners
- ☐ High cholesterol

Abdominal/GI
- ☐ Hernia
- ☐ Nausea or vomiting
- ☐ Reflux
- ☐ Peptic ulcer
- ☐ Jaundice

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Hormonal abnormalities
- ☐ Steroid use

Oncologic
- ☐ Chemotherapy
- ☐ Radiation

Male Reproductive
- ☐ Problems with prostate gland
- ☐ Abnormal PSA
- ☐ Difficulty urinating
- ☐ Testicular pain or mass

Female Reproductive
- ☐ Irregular menstruation
- ☐ Vaginal spotting
- ☐ Ovarian cysts
- ☐ Vaginal discharge
- ☐ Endometriosis

Number of previous pregnancies:___

Rheumatologic
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Arthritis

Neurological/Psychiatric
- ☐ Stroke
- ☐ Seizure
- ☐ Fainting or blackouts
- ☐ Anxiety
- ☐ Phobia
- ☐ Depression

Respiratory
- ☐ Recent cough
- ☐ Productive cough with sputum
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Wheezing

Colorectal
- ☐ Fecal Incontinence

Personal Habits
Do you smoke?
Yes No
Do you drink alcohol?
Yes No

Other

_____

_____

_____

Primary Care Physician

_____
(name)

Other Physicians

_____

_____

_____

Patient Signature: _____ Date: _____

I have reviewed the above information with the patient on this date. All boxes which are not checked are either negative or N/A.

Physician Signature: _____ Date: _____

Office Financial Policy

It is the policy of this office to receive payment at the time that services are rendered.

We strive to provide the utmost in care and minimize any difficulties in the processing of medical billing. We participate in most insurance plans, including Medicare.

If we are a participating provider for your insurance company, the co-pay or the insured's responsibility is due at the time of the office visit.

If you are insured by a plan we do business with, but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage.

Knowing your benefits is your responsibility. We will do our best to provide an accurate estimate of the costs of services prior to your appointment. Please be aware, however, that these are just estimates and may not reflect actual costs. Please contact your insurance company with any questions you may have regarding your coverage.

If you are not insured by a plan we do business with, payment in full is expected at each visit unless other arrangements have been made in advance.

Referrals are the patient's responsibility. In the event that an insurance claim is denied because of failure to obtain a referral, the fees for services will be the patient's responsibility.

Fees for planned surgeries require 50% deposit and will be filed with your insurance company. We will pre-certify all surgeries for you.

Should you be hospitalized and under our care, doctor's fees while you are hospitalized will be billed to your insurance company. All funds received from your insurance company will be promptly applied to your balance.

We will bill you three times for overdue bills. If the outstanding balance is not paid after three statements, we will send the account to a collections agency for processing. For all unpaid balances, a handling fee of $10.00/month will be added to your balance commencing with the second month of billing.

Treatments may not be covered under some insurance policies and prompt payment is the patient's responsibility.

If you are covered by two insurance policies, you will be required at the time of service for the co-pay from the primary provider. We do not process claims for co-pays. However, we will provide a receipt after the primary insurance pays the claim for you to submit to your secondary policy.

As a courtesy, we will file claims for your primary and secondary insurance. You are responsible for claims with any additional providers.

I have read and understand the Financial Policy above.

_____ _____

Legal Signature Date

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My signature below is acknowledgement of receipt of the
Notice of Privacy Practices from this office

Name of Patient (please print)	Signature of Patient	Date

Signature of Patient Representative (required if patient is a minor or unable to sign)	Relationship to Patient	Date

Persons Authorized to Receive Information

Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth
Name of Person	Relationship	Date of Birth

_____ (please initial) I authorize the person(s) listed above to receive *all health information* about appointments, treatment, insurance, and/or other information contained in my records.

_____ (please initial) I do not authorize the following information to be released to anyone other than myself: (please specify) _____

Telephone Preferences

Please give us permission or denial for calling you in reference to appointments, schedule changes, etc.
We do not give out medical information except to you and your authorized representatives, and we do not leave sensitive information on a message.

Please circle your responses

May we call you at your home number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A
May we call you at your work number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A
May we call you at your mobile number?	YES	NO	N/A	May we leave a message?	YES	NO	N/A

Signature of Patient or Patient Representative	Date

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Patient/Provider Care Agreement

Practice Responsibilities

- We will strive for excellence in all aspects of patient care.
- We will treat you with the utmost of respect and courtesy.
- We will be professional and discrete when caring for you.
- We will be respectful of your time and always strive to keep your scheduled appointment time, with the understanding that unforeseen emergencies, on occasion, make this impossible.
- We will submit claims to insurance companies with whom our office has agreements.
- We will communicate with you in a clear and timely manner.
- We will share your medical information only with appropriate medical personnel and those that you specifically designate.
- We will keep thorough records of the care you receive from us.
- We will assist you in providing copies of your medical records or assist you in completing forms for a reasonable fee.

Patient Responsibilities

- Patients will be responsible for the payment of any additional deductible, co-insurance or co-pay at time of service.
- Patients are ultimately responsible for knowing and understanding their insurance plan benefits and how they will be applied to the various services they may be provided.
- Patients should provide accurate insurance information prior to the initial visit, along with updates as necessary.
- Patients must consent to the release of medical information to all pertinent insurance companies, plan administrators, third party payers, and claim reviewers.
- Patients are ultimately responsible for obtaining referrals from Primary Care Physicians when necessary. We will assist with this process as we are able.
- Patients should arrive for appointments in a timely fashion, and 30 minutes prior to the initial visit to complete paperwork.
- Patients must provide at least (24) hour notice for appointment cancellation. Failure to provide this notice prevents us from offering your valuable spot to someone who needs it and therefore a $40.00 fee will be assessed.
- Patients should cooperate fully with the doctor, therapists, and staff in carrying out the designated treatment plan.
- Patients will complete (or update) a Patient Demographics Form every 6 months.
- Patients will notify our office of changes to personal information and/or insurance carriers.
- Patients are ultimately responsible for understanding their obligations to other providers of medical care such as hospitals, outpatient facilities, labs, anesthesia and pathology providers. These entities will bill separately and are not subject to any direction from our practice.
- Patients are ultimately responsible for prior authorization and pre-certification as may be required by the insurance companies. We will assist with this process as we are able.
- In respect of others and in order to assure complete focus, patients will refrain from bringing children to their appointments.

By signing below, you understand the above responsibilities and agree that they are valid and provide your consent to treat. If you do not understand these responsibilities or need further clarification, please ask a staff member before signing.

Signature _____ Date _____

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Signature _____ Date _____

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.

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.

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 restriction).

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 in HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services
You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of September 23, 2013.

Patient Signature_____Date_____