EVANGELION
MEDICAL

Previously known as P. Douglas Cochran, MD, LTD

Account (Patient ID) #_____

15 Smith Rd • Suite 3004
Midland, TX 79705
www.evangelionmedical.com
Phone: 432-699-6000
Fax: 432-699-6012

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_____

Date of Birth:_____Social Security Number: _____

Email Address:_____Preferred Pharmacy: _____

Spouse's Name: _____Employer 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: _____

Parent's Place of Employment:_____Work Phone #: _____

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 #:_____Group #_____

Name of Insured:_____SS#_____DOB:_____

Relationship to Patient:_____

SECONDARY Insurance Co._____ID #:_____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 Evangelion Medical 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 Evangelion Medical 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 Evangelion Medical. to the patient.

_____ _____

Signature of Patient (or Responsible Party) Date

3. AUTHORIZATION OF PAYMENTS

I understand that Evangelion Medical will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Evangelion Medical. 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 Evangelion Medical. 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 Evangelion Medical employs physician assistants and nurse practitioners. I hereby authorized that a physician assistant or nurse practitioner, under the supervision of the attending physician, may render my medical care jointly. I authorize the physician assistant and/or nurse practitioner to communicate my diagnosis and treatment with his or her supervising attending physician, as well as, with other health care practitioners involved in my care. I authorize the admittance of qualified observers, including medical students, during my consultation and/or examination.

_____ _____

Signature of Patient (or Responsible Party) Date

6. MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Evangelion Medical for any services furnished me by the physicians. I authorize any holder of medical information about me to release to Evangelion Medical for Medicare Services and its agents any information needed to determination these benefits or the benefits payable for related services.

_____ _____

Signature of Patient (or Responsible Party) Date

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have read and understand Evangelion Medical'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.evangelionmedical.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 Evangelion Medical. 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 $50.00 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 paper medical records for legal, insurance, or private use will incur a fee of $25.00 for the first 20 pages and $0.50 per page thereafter. A request for records in electronic format will incur a fee of $25.00 for 500 pages or less and $50.00 for more than 500 pages.

Additional Provider Paperwork Terms:

Requests for additional paperwork such as form completion, disability paperwork, or supplemental insurance paperwork will incur a fee of $200.00 per activity or may be completed during a scheduled appointment that is solely for this purpose. For paperwork requiring minimal information and only a physician signature, there be will a 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 Evangelion Medical 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 24 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. Dr. Cochran does not admit patients to or see them 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 must be accompanied by a translator or be rescheduled. Except for parents of minors, only one visitor may accompany each patient in the exam room.

The offices of Evangelion Medical strongly prefer not to participate or testify in insurance or law-suit cases, Workman's Compensation cases, or Disability exams. Effective June 14, 2023, All actions and court appearances undertaken by the physicians and providers at Evangelical Medical because of a subpoena or other legal action will result in respective fees incurred by the issuing party. A full fee schedule is available upon request. The party who issues the subpoena will be responsible for all fees incurred, but this does not mean that testimony or records produced will be solely in your favor. Testimony must be based strictly on the facts of the case and this physician's / provider's professional opinion, including when answering questions from opposing counsel.

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 _____

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 (7-10 drinks/week) ☐ heavy (more than 10 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** _____

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MEDICAL

Phone: (432) 699-6000
Fax: (432) 699-6012

Controlled Substances Policy

Controlled substances include but are not limited to:

Narcotics (hydrocodone, norco, vicoden, vicoprofen, tramadol, etc.)
Stimulants (most types of ADD/ADHD meds, certain weight loss medications, etc.)
Benzodiazepines (Xanax, klonopin, valium, etc.)
Hypnotics (ambien, Lunesta, 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. In general, Evangelion Medical will not provide ongoing narcotics.

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 policy, we will be happy to try and refer to an appropriate specialist. However, we 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. There must also be a follow-up appointment at least every 3 months. Additionally, certain insurance companies require that patients on controlled substances must have a face-to-face nurse appointment every month. Any controlled substance prescription given without an appointment incurs a $20.00 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 generally 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 periodic visits in which a refill is requested or at the provider's request. 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 who already see a specialist or any other physician who prescribe specific controlled substances will not be prescribed those medications by this office. This includes pain doctors, orthopedists, or psychiatrists.

If a patient who is seeing a specialist or another physician chooses to stop that relationship or is dismissed by that practice, it will be the patient's responsibility to find another provider 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.

Sincerely,
P. Douglas Cochran, MD and the Evangelion Medical Team.

(Updated May 17, 2023)

Signature of Patient (or Responsible Party) Printed Name Date

EVANGELION
MEDICAL

Phone: (432) 699-6000
Fax: (432) 699-6012

Patient ID / Account Number:_____

Consent to Communicate

The team at Evangelion Medical has my permission to contact me at the following phone numbers. Please circle the primary preferred option.

Type of Phone	Phone Number	Permission to leave **detailed** message on voicemail? (This will include test results and recommendations.)	Permission to leave **basic** message on voicemail? ("This is Dr. Cochran's office. Please return our call…")
Cell Phone		○ YES | ○ NO	○ YES | ○ NO
Home Phone		○ YES | ○ NO	○ YES | ○ NO
Work Phone		○ YES | ○ NO	○ YES | ○ NO
Other		○ YES | ○ NO	○ YES | ○ NO

Please indicate if you would like to receive notification via mail for normal lab results: ○ YES | ○ NO
If yes, please provide your mailing address:_____city:_____state:_____zip:_____

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

Permission to Share Health Information with Family/Friends

Date of Permission	Name of individual & Relationship to patient	Comments/1nstructions (i.e. may pick up meds, may disclose test results, etc.)	Patient/Guardian Initials

By signing below, I give permission to the person(s) above to receive limited information about my care. I understand my healthcare provider will use his/her professional judgment to ensure that information is shared with my family/friend(s) 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 a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

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

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MEDICAL

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Court Action and Subpoena Policy

Please note that this policy is purposefully designed to discourage patients from having their physician / provider subpoenaed in civil court matters. This not only in the best interest of Evangelion Medical physicians and providers but is also in the best interest of all patients of the practice. Court appearances, depositions, preparation times, and other legal matters take time away from the patients. Physicians and providers are forced to focus on matters of law instead of matters of healthcare and medicine, which is not what is in the best interest of patients, staff members, or the community at large.

All actions and court appearances undertaken by the physicians and providers at Evangelical Medical because of a subpoena or other legal action will result in respective fees incurred by the issuing party. A full fee schedule is available upon request.

The party who issues the subpoena will be responsible for all fees incurred, but this does not mean that testimony or records produced will be solely in your favor. Testimony must be based strictly on the facts of the case and this physician's / provider's professional opinion, including when answering questions from opposing counsel.

I acknowledge that I, the patient or guardian of the patient, have received this notice declaring that there are all fees associated with issuing a subpoena or another legal mechanism requiring action on the part of Evangelion Medical or any of its physicians or providers. I acknowledge that I can request a full fee schedule if this is desired.

Patient Name (please print): _____

Patient Signature: _____