FAMILY MEDICINE ASSOCIATES OF TEXAS, PA

Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your needs, please fill out this form completely. You will be asked to update this information every twelve(12) months due to our changing healthcare environment. We will also ask you for a copy of your Insurance Card(s) and a copy of your Driver's License.

Today's Date _____ Date of Birth _____ Preferred Name _____

Patient Last Name _____ First Name _____ Middle _____

Address _____ City/State/Zip _____

Person responsible for payment _____ Patient relationship to responsible party _____

Address _____ Phone # _____

City/State/Zip _____

Primary Phone (_____) ☐OK to leave message on machine with detailed appointment / medical information

_____ ☐OK to leave message with our office name and call back number only

Secondary Phone (_____) ☐OK to leave message on machine with detailed appointment / medical information

_____ ☐OK to leave message with our office name and call back number only

Email Address _____

Emergency Contact _____ Relationship _____ Phone _____

How were you referred to our office? ☐Friend ☐Family ☐Facebook ☐Twitter ☐Insurance ☐Print Ad

Referring Doctor or Facility _____ Other _____

Explanation of Complete Physical

The physical will be performed in two parts. The first part includes blood tests and a discussion with your doctor of medical problems and symptoms you may be having. The office visit and non-routine blood work will be billed under a medical diagnosis. The second part of the physical will include review of your test results. If you are treated for a medical condition during your physical, non-routine fees will be submitted separately from the routine complete physical.

You may wish to contact your insurance company to see if routine benefits are covered. The company may have a maximum dollar limit for routine care. Your physician cannot always be sure that the cost will be under that dollar amount. Our staff can discuss acceptable payment arrangements for any of these services.

Waiver for possible Non-Covered Service

Routine/preventative services to include but not limited to complete physicals, school, sports, and camp physicals, travel counseling, immunizations, pap smears, well child appointments, and flu shots may not be covered by your insurance company.

I understand that my insurance company may or may not cover these services or labs being performed today. Some insurance companies may pay a portion and others may not cover these services at all. If you have a large deductible, some or all of this may go to your deductible. I understand this and I am willing to be responsible for charges not covered by insurance.

_____ _____

Signature (Patient/Guardian) Date

FAMILY MEDICINE ASSOCIATES OF TEXAS, PA

Financial Policies and Responsibility

- Copayment is due at the time of the visit. If you do not have your co-payment, we will ask that you reschedule your appointment.
- If you have not met your deductible, you are expected to pay in full at the time of the visit.
- Please note that we do not honor lab cards (such as LabOne or Lab Direct) or others that take the choice of lab where the patient is sent, away from our provider.
- We charge the insurance carriers our "normal fees". We are paid their allowable amounts, and write off the difference between those two amounts as the discount. We do not write off amounts that have gone to the deductible, non-covered services, or co-payments.
- After your insurance company has paid their portion, if there is any amount not covered due to your deductible, non-covered services such as preventive care, etc., we will send you a bill for the amount due. We ask that you remit the owed amount upon receipt of the bill.
- It is ultimately the patient's responsibility to be aware of their plan's limitations and restrictions on covered services.
- If you need a referral to a specialist, we will ask that you see one of our physicians first. We need specific information and documentation in our files in order to obtain authorization for you to see another doctor, be hospitalized, or have certain procedures.
- Failure to keep the patient's account current may result in Family Medicine Associates of Texas, P.A. being unable to provide additional services except for emergencies.
- We reserve the right to charge you (not your insurance company) an office fee if you do not cancel your appointment within 24 hours of your appointment time, or if you no-show for your appointment.

(Please Initial below)

_____ I hereby authorize Family Medicine Associates of Texas, P.A. to release any information concerning my condition and treatment or examination (including HIV, psychological records and all forms of communication) rendered to me, my child or person under my legal guardianship, to the insurance carrier and/or healthcare provider(s) involved in my healthcare.

_____ I authorize and request the insurance company to pay directly to Family Medicine Associates of Texas, PA for benefits otherwise payable to the patient.

_____ I understand the insurance company may not pay the actual bill for services, and I agree to be responsible for payment of all services rendered for myself, my child or the person under my legal guardianship.

_____ I understand that Family Medicine Associates of Texas, P.A. does not file on Champus/ TriCare.

_____ Patient or his/her legal representative accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

Signature below is acknowledgement that you have read our HIPAA Notice of Privacy Practices and Financial Policies:

Print Name: _____ Date of Birth: _____

Signature _____ Date: _____

Please list any other individuals or family members that you authorize access to your medical information:

_____ _____

_____ _____

For Office Use Only: ☐ Complete Physical ☐ Other

Name _____ DOB _____ Age _____ Today's Date _____

Preferred Name _____

Past Medical History

Current Medications & Dosages

Medication	Dosage	Medication	Dosage

What medications are you allergic to and what kind of reaction did you have? _____

_____

Do you take herbs or supplements? ☐ Yes ☐ No Which ones? _____

List all diseases you have or have had in the past:

☐ High Blood Pressure ☐ Elevated Cholesterol ☐ Cancer ☐ Diabetes ☐ Thyroid Disease ☐ Heart Disease

☐ Others _____

Hospital Admissions / Surgeries / Procedures / Biopsies

Year		Year	

Family History

Father: ☐ Living - Illness _____ ☐ Deceased - Cause of death _____ Age at death _____

Mother: ☐ Living - Illness _____ ☐ Deceased - Cause of death _____ Age at death _____

Has any parent, brother or sister had: (Please indicate which relative and approximate age at diagnosis)

(A.) ☐ Colon Cancer ☐ Ovarian Cancer ☐ Thyroid Cancer ☐ Heart Disease (before age 55 if male, or age 65 if female)
☐ Colon Polyps ☐ Prostate Cancer ☐ Breast Cancer ☐ Osteoporosis (bone thinning) ☐ Melanoma

(B.) ☐ Stroke ☐ Diabetes ☐ Bleeding Disorders ☐ Alcoholism
☐ Glaucoma ☐ Kidney Disease ☐ Arthritis ☐ Depression

Social History

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner # of Children _____

Alcohol: _____ drinks per week

Have you ever had problems with alcohol use? ☐ Yes ☐ No

Have you ever felt you needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

Have you ever felt you needed a drink first thing in the morning (eye opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes How many packs per day? _____ For how many years? _____ ☐ No ☐ Quit, When ? _____

Do you chew tobacco or use snuff? ☐ Yes Tobacco or Snuff? _____ How much? _____ For how many years? _____ ☐ No ☐ Quit, When ? _____

Recreational Drug Use / Substance Abuse (injections or other): ☐ Yes ☐ No ☐ Past Which substances? _____

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender Female ☐ Transgender Male ☐ Other

What type of exercise do you do? _____ How often? _____

Name:_____

☐ **REVIEW OF SYMPTOMS** Date:_____

CHECK ☑ THE BOX FOR CURRENT PROBLEMS

Your 3 Main Problems: (1) _____(2)_____(3)_____

General
- ☐ Fatigue/Weakness
- ☐ I do not feel rested when I wake up
- ☐ I am not satisfied with my sleep
- ☐ I am very sleepy during the day
- ☐ I fall asleep easily during the day
- ☐ Unhappiness
- ☐ Depression/Sadness
- ☐ Have felt down or hopeless for several months
- ☐ Have little interest/joy in usual activities
- ☐ Tearfulness
- ☐ Feelings of worthlessness
- ☐ Concentration difficulty
- ☐ Excessive irritability
- ☐ Lack of motivation
- ☐ Moodiness
- ☐ Nervousness/Anxiety
- ☐ Always feel ill
- ☐ Unexplained fever >100
- ☐ Frequent night sweats
- ☐ Weight loss - recent
- ☐ Weight gain
- ☐ Allergies
- ☐ Anemia
- ☐ Phobias
- ☐ Mental Illnesses

Skin
- ☐ I have a mole(s) I want you to check
- ☐ Changes in moles/unusual moles
- ☐ Are you concerned about skin spots/growths?
- ☐ Bruise easily
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Psoriasis
- ☐ Dry skin
- ☐ Excessive hair growth
- ☐ Hair Loss

Ears/Nose/Throat
- ☐ Allergy symptoms
- ☐ Frequent colds
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Ear infections - frequent
- ☐ Dizzy spells - dizziness
- ☐ Nose Bleeds - frequent
- ☐ Sinus trouble
- ☐ Sore throat - frequent
- ☐ Hoarseness - frequent
- ☐ I would like allergy testing
- ☐ Non-healing mouth sores
- ☐ Childhood head/neck irradiation

Eyes
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Eye Pain
- ☐ Double or blurred vision
- ☐ Other visual disturbances

Lungs
- ☐ Pneumonia
- ☐ Asthma/Wheezing
- ☐ Cough - persistent
- ☐ Coughing blood
- ☐ Snoring
- ☐ Stop breathing/gasp at night
- ☐ TB/Positive TB skin test

Heart/Circulation
- ☐ Shortness of breath
  - ☐ On exertion ☐ Lying flat
- ☐ Chest Pain or Chest Discomfort
- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Palpitations/Racing heart
- ☐ Irregular pulse
- ☐ Fainting spells
- ☐ Swollen ankles
- ☐ Leg pain with walking
- ☐ Varicose veins
- ☐ Cold/Numb feet
- ☐ Phlebitis – Blood clots

Gastrointestinal
- ☐ Change in bowel habits - recent
- ☐ Indigestion or heartburn
- ☐ Loss of appetite - recent
- ☐ Difficulty swallowing
- ☐ Persistent nausea/vomiting
- ☐ Peptic ulcers
- ☐ Swallowing pain
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids
- ☐ Gallbladder problems
- ☐ Hepatitis/Jaundice
- ☐ Require laxative – How often?

Genital/Urinary
- ☐ Hernia
- ☐ Urine infections - frequent
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urinary leakage/Incontinence
- ☐ Blood in urine
- ☐ Overnight urination x 2
- ☐ Loss of control of urination
- ☐ History of sexually transmitted diseases?
- ☐ Are there sexual issues or dysfunctions you want to discuss?
- ☐ Loss of interest in sex

Male
- ☐ Decrease in force of urination
- ☐ Erection problems
- ☐ Too rapid ejaculation
- ☐ Testicle lumps/swelling

Female
- ☐ Pain/Bleeding during or after sex
- ☐ Vaginal discharge/itching
- ☐ Abnormal Pap smear
- ☐ Flushing/Menopause symptoms
- ☐ Significant pain/cramps with periods

Breast
- ☐ Pain
- ☐ Cysts
- ☐ Lumps/Nodules
- ☐ Nipple discharge
- ☐ Biopsy of a nodule/lump

Female Menstrual History

Age of Onset _____ ☐ Reg ☐ Irreg ☐ Menopause

Flow: ☐ Heavy ☐ Moderate ☐ Light

_____Days of flow _____ Length of cycle

# of pregnancies _____

# of live births _____

# of miscarriages/other _____

Birth control method _____

Central/Peripheral Nervous System
- ☐ Headaches - frequent
- ☐ Seizures/convulsions
- ☐ Stroke
- ☐ Memory loss
- ☐ Tremor/Hands shaking
- ☐ Dizzy/Lightheaded
- ☐ Muscle wasting
- ☐ Numbness/Tingling sensations

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain - recurrent
- ☐ Bone pain/fracture
- ☐ Gout
- ☐ Foot pain

Miscellaneous

Date of last tetanus booster shot_____

Have you ever been physically hurt by your partner?

☐ Yes ☐ No

Blood transfusion before 1992? ☐ Yes ☐ No

I want sexually transmitted disease testing ☐ Yes ☐ No

I want HIV testing ☐ Yes ☐ No

Frequent foreign travel? ☐ Yes ☐ No

I would like more information on
- ☐ Allergy testing
- ☐ Participating in Research Studies

Other

Other diseases or symptoms or concerns

_____

_____

_____

Explanation: _____

_____

Note to MD or PA: Write "P" next to any symptom discussed on Progress Note (P = see PN)

Medical Records Authorization for Release of Medical Information

Patient Name: _____ Date: _____

DOB: _____ SS#: _____ Phone #: _____

Address: (Street) _____

(City) _____ (State) _____ (Zip) _____

BY STATE LAW YOU MUST BE ADVISED THAT: The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as "AIDS".

I hereby authorize: _____

_____

_____

Phone: _____ Fax: _____

Release the following health record information of the above-named patient, for the following purpose:

☐ Insurance ☐ Medical ☐ Other: _____

The information to be released is:

☐ All Records ☐ History & Physical Exam ☐ Consultation
☐ X-Ray Reports ☐ Operative Reports ☐ Lab / Pathology
☐ Other: _____

This information is to be released to: (Name) _____

(Address) _____

Phone: _____ Fax: _____

This authorization will remain in force from the date of my signature until revoked upon written notification. Withdrawal of consent does not affect any information disclosed ***prior*** to the written notice of withdrawal. THERE MAY BE A FEE CHARGED FOR RECORD COPYING.

REDISCLOSURE: This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.

_____ _____

Witness Signature Date Patient/Legal Guardian Signature Date

FAMILY MEDICINE ASSOCIATES OF TEXAS, PA

HIPAA 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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, or office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is **not** required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (972) 394-8844.