FAMILY MEDICAL CENTER

Child New Patient Registration 2024

Name		Date of Birth
Address		Gender ☐ Male ☐ Female
City	State	Zip Code
Home Phone	Cell Phone	Social Security #
Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
Patient's/Parent's Employer		
Whom may we thank for referring you?		
Emergency Contact		Phone

Must be completed for minor children

Guarantor	Relationship to Patient
Address	
Home Phone	Cell Phone
Date of Birth	Social Security #

Our Privacy Practices

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI and requests for PHI be limited to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. *Uses and disclosures may be permitted without prior consent in an emergency.*

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

Telephone as listed above: ☐ Leave a message with detailed information ☐ Detailed text message ☐ Leave a message with callback # only	Written Communication at: ☐ Home address ☐ Email listed above ☐ FAX _____
This release authorizes Family Medical Center to discuss non-sensitive medical information with: ☐ Patient Only ☐ Spouse ☐ Parent ☐ Other (specify) _____	
I have reviewed and/or reviewed a copy of Privacy and Your Health Information regarding HIPAA privacy practices. ☐ Yes ☐ No	

_____ _____

Patient/Guarantor Signature Date

FAMILY MEDICAL CENTER

Financial Policy 2024

Thank you for choosing Family Medical Center as your primary healthcare provider.

Please read and sign our Financial Policy prior to seeing a provider. Ask our business office staff if you have questions.

1. Your insurance policy is a contract between patient, employer and insurance. FMC is NOT a party to that contract.
2. FMC is in network and accepts assignment from most major insurance carriers and Medicare.
3. Insurance payments do not cover full costs for all services. Service fees and/or membership fees are sometimes required.
4. FMC Club Membership has benefits: appointment availability and many included services and fee waivers.
5. All charges are your responsibility whether your insurance carrier pays or not.
6. Fees for services, along with unpaid deductibles, co-insurance and co-payments, are due at the time of treatment.
7. Please be aware that some or all of the services you receive may be considered non-covered by insurers or Medicare. You must pay for known non-covered services in full at the time of service.
8. A **$30.00 service fee** or statement fee will be assessed for:
   Failure to **update insurance** card and **driver's license** on file, before each service,
   Appointment **no-shows** or cancellations with less than 24 hours notice,
   Patient **balances not paid** at the time of service, with a statement **fee added monthly,**
   Unpaid **insurance balances** after 30 days,
   Returned Checks due to insufficient funds may be re-presented to bank ($30) as permitted by law.
   (Referral after 10 days to the Williamson County Attorney, with no further checks accepted.)
9. If your insurance carrier does not pay your balance in full within 30 days, contact your carrier to request prompt payment.
10. Please call at least 24 hours in advance to cancel an appointment, so that we may offer that time to another patient in need. Patients arriving more than **10 minutes late** for a scheduled appointment will be asked to **reschedule**, and incur a $30 fee.
11. Unpaid balances over $50 and over 90 days past due may be referred to a collection agency or small claims court. All collection fees are the sole responsibility of the patient/guarantor. If an account is placed in collections, the patient/guarantor agrees to reimburse Family Medical Center for up to 30% above the debt for collection agency fees, and additionally, any attorney's fees and other costs incurred in such collection efforts.
12. In accordance with AMA CPT guidelines, we charge for telephone as well as telemedicine calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance carrier for such calls similar to office visits, with co-pays or deductibles or non-covered charges, depending on your insurance.
13. Completion of forms such as FMLA, Disability, and Disabled Placard applications are subject to a $30.00 charge in addition to office visit charges.
14. A patient or guardian may request a copy of their medical record in writing with a signed Release of Information form, requiring 10 days for processing. There is no charge for records sent directly to a physician/clinic for continued care. Other use requires payment of $25.00 for up to 50 pages, and $0.50 per additional page. We comply with HIPAA confidentiality and records security guidelines.

We understand that unforeseen circumstances and temporary hardships may affect timely payment of your balance. Communicate any such problems so that we can assist you in the management of your account.

I agree that I have read and understand this document in its entirety. I have had the opportunity to ask and have my questions answered to my satisfaction. I certify that I am the patient or am duly authorized by the patient or by law to execute the following agreement and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I authorize the release of any medical records or demographic information necessary to process my insurance claims. I hereby assign to Family Medical Center, the healthcare benefits I am entitled from my insurance company(s) and/or Medicare CMS.

_____ _____

Patient/Guarantor Signature Date

FAMILY MEDICAL CENTER

Agreement to Treatment 2024

Thank you for choosing Family Medical Center as your primary medical care provider. If you have any questions or concerns about the following information, please do not hesitate to ask your provider, nursing staff or business office staff. We ask that all patients read and sign this notice prior to seeing a medical care provider.

Medicine is a unique practice. Every individual and every medical problem is different. We practice medicine one patient at a time, which is good news for you! In this practice, it is not uncommon for patients to be inconvenienced by a wait. Although we make every effort to ensure that patients are seen in a timely manner, emergent or unexpected needs of other patients may cause delays. We respect your schedule and apologize for any inconvenience. Our staff will keep you informed so that you may choose to wait or to reschedule. We value our staff and are committed to providing exceptional medical care and customer service. We expect that our patients give our staff and us the same respect and professionalism they receive.

Test Results – While some routine results on labs and imaging may be available in 24 hours, some take longer. Provider chart review takes another 3 business days. Patients may receive the results of their laboratory tests or diagnostic imaging via text messaging, secure email, patient portal or telephone, whichever the patient prefers. Most CPL lab results online via the SonicMyAccess portal at https://cpl.luminatehealth.com/ with a user login. We will call the patient personally, and are happy to print a paper copy, or arrange prompt follow-up via appointment or tele-med for questions or concerns on any results that are significantly out of range.

Medication Refills – ***Medication refills must be requested at the patient's pharmacy 5-7 days before they are needed, allowing our office 3 business days to process requests.*** The pharmacy will fax/transmit a Medication Refill Request that provides all the information necessary for the providers to consider a prescription refill. Refill requests may be denied if a refill is requested too soon, if labs or follow-up are needed, or for various other reasons.

- Patients requiring regular schedule II medication refills (with a 30 day quantity limit) must call our office to request a refill at least 72 hours in advance. Patients will receive a $30 charge per schedule II refill authorized. A follow-up appointment and or urine drug screen is mandatory every 3 months.
- We do not refill controlled (III-V) pain, anxiety, or sleep medications without a regular office visit.
- New medications, or significant changes in medications generally require an appointment.
- Medications will not be refilled outside of regular office hours.

After Hours – Routine office hours are from 8:30 am – 12:00 pm and 1:00 pm – 4:30 pm, Monday through Friday. Should a patient need to contact a provider outside regular office hours, the clinic's after hours recording provides instructions for after hours callers. Emergencies must dial 911 immediately, rather than leaving a message on the FMC telephone system.

I am voluntarily seeking healthcare and hereby consent to medical treatment, procedures, laboratory tests and other healthcare services. I have the right to refuse specific treatments or procedures. I agree that I have read and understand this document in its entirety. I certify that I am the patient or am duly authorized by the patient or by law to execute the following agreement. I authorize the release of any medical records or demographic information necessary to consulting physicians, clinics, hospitals, therapists, or testing facilities for my continued care.

_____ _____

Patient/Guarantor Signature Date

FAMILY MEDICAL CENTER

Informed Consent for Telemedicicne Services 2024

Telemedicine involves the use of electronic communications to enable healthcare providers and individual patients to share medical information for the purpose of improving patient care. The information may be used for diagnosis, follow-up and/or education, remote physical monitoring and may include any of the following:

1. Patient medical records
2. Medical images
3. Live two-way audio and video
4. Live audio only
5. Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Responsibility for the patient care should remain with the patient's local clinician, if you have one, as does the patient's medical record.

Expected Benefits:

1. Improved access to medical care by enabling a patient to remain in his/her home.
2. More efficient medical evaluation and management.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled video consult;
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By signing below, you acknowledge that you understand and agree with the following:

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed without my written consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand the alternatives to telemedicine as they have been explained to me, and in choosing to participate in a telemedicine, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the consulting healthcare provider.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above mentioned individuals will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I have read this document carefully, and understand the risks and benefits of the telecmedicine consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine visit under the terms described herein.

_____ _____

Patient/Guarantor Signature Date

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PEDIATRIC HEALTH HISTORY

Completed By: _____ Relationship to Child: _____

List an medications, vitamins or over-the-counter medications your child takes:

List any drug, food or environmental allergies your child has:

Ar your child's immunizations up-to-date? ☐ Yes ☐ No ☐ Never Received Vaccines

Is your child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Guardianship ☐ Foster Child ☐ Other

Was the birth: ☐ Vaginal ☐ C-section

Birth Weight: Birth Length:

Was the baby preterm? ☐ Yes ☐ No If yes, how many weeks gestation?

Did the mother take any medications or other drugs/substances during the pregnancy? ☐ Yes ☐ No

If yes, please give details:

Were there any problems during the birth or newborn period?

Please list any hospitalizations or surgeries your child has had with dates:

Please list or describe any major medical problems with dates:

Please check any problem that your child has (or has had in the past) and note how old they were at the time:

		Age			Age
	Asthma			Heart Problems/Heart Murmur	
	Allergies			Learning/School Problems	
	Bedwetting/daytime accidents			Menstrual Problems	
	Behavior/Emotional Problems			Physical/Sexual Abuse	
	Broken Bones			Scoliosis/Back Problems	
	Cerebral Palsy			Skin Problems	
	Chicken Pox			Sleep Problems	
	Chronic Constipation			Seizures	
	Depression/Anxiety			Sexual Concerns	
	Diabetes			Urinary Infections	
	Frequent Headaches			Vision Problems	
	Hearing Problems			Other Problems	

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Father's Name: _____ Father's Age: _____

Father's Occupation: _____ Education Completed: _____

Mother's Name: _____ Mother's Age: _____

Mother's Occupation: _____ Education Completed: _____

Check all the people that live with your child:

☐ Mother ☐ Father's ☐ Brother(s) ☐ Sister(s) ☐ Step-parent ☐ Grandparent(s) ☐ Other

Sibling Name: _____ Date of Birth: _____

Sibling Name: _____ Date of Birth: _____

Sibling Name: _____ Date of Birth: _____

Sibling Name: _____ Date of Birth: _____

Are the child's parent? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

During the past year, have there been any of the following changes in your family?

☐ Marriage ☐ Separation ☐ Divorce ☐ Serious Illness ☐ Birth(s)

☐ Loss of Job ☐ Death(s) ☐ Other

Do any household members smoke? ☐ Yes ☐ No

If there a family history of any of the following problems?

	ADD/ADHD		Adult Onset Diabetes
	Alcohol Abuse		Allergies
	Asthma		Birth Defect
	Bleeding/Clotting Problems		Cancer
	Childhood Onset Diabetes		Deafness
	Domestic Violence		Drug/Substance Abuse
	Heart Disease		Hereditary Disease
	High Cholesterol		Hypertension
	Kidney Problems		Learning Problems
	Mental Illness/Suicide		Seizures
	Stroke		Stomach/Bowel Problems
	Sudden Unexplained Death		Other