FAMILY MEDICAL CENTER

Patient Registration

Thank you for selecting Family Medical Center for your primary health care needs. We will strive to provide you with the best possible health care. If you have any questions or need assistance, please ask us – we will be happy to help!

Name		Date of Birth	
Address		Gender ☐ Male ☐ Female	
City	State	Zip Code	
Home Phone		Cell Phone	
Email		Social Security #	
Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated			
Patient's or 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 message with detailed information ☐ Detailed text message ☐ Leave message with call back number only

☐ Written Communication at: ☐ Home Address ☐ FAX ☐ Email as listed above

This release authorizes Family Medical Center to discuss non-sensitive medical information with:

☐ Patient Only ☐ Spouse ☐ Parent ☐ Other (please specify)

I have received 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

Thank you for choosing Family Medical Center as your primary healthcare provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a provider.

We accept assignment from most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract.
2. All charges are your responsibility whether your insurance carrier pays or not.
3. Fees for services, along with unpaid deductibles, co-insurance and co-payments, are due at the time of treatment.
4. A $10.00 service fee will be assessed if deductibles, co-insurance and/or co-payments are not paid at the time of service.
5. If your insurance carrier does not pay your balance in full within 30 days, we may ask that you contact your carrier to request prompt payment.
6. Any changes in insurance coverage, employment, address, and/or telephone number must be provided to the receptionist upon check-in. If the patient's insurance carrier fails to verify coverage, the patient/guarantor must pay for services in full at the time services are rendered. At all times, the office must maintain on file, a copy of the patient's insurance card and the patient/guarantor's driver's license.
7. Checks returned by the bank due to non-sufficient funds or account closures will incur a returned check fee of $30.00 and may be represented electronically or by paper draft and your bank account will be debited or drafted for the check amount, service fees, and related expenses permitted by law. Any check not paid, along with the fees, within 10 business days, ***WILL*** be turned over to the Williamson County Attorney for prosecution. Additional checks will not be accepted.
8. If you are unable to keep your scheduled appointment, please call at least 24 hours in advance so that we may offer that appointment to another patient in need and reschedule your appointment for another time. If you fail to cancel your appointment, you will be charged a $25.00 missed appointment fee. ***Patients who arrive more than 10 minutes late for a scheduled appointment (5 minutes for a sick visit) will be asked to reschedule their appointment.***
9. Unpaid balances over 60 days may be assessed a $20.00/month billing fee**.**
10. Unpaid balances over 90 days may be subject to collections via small claims court, attorney and/or collection agency. All collection fees are the sole responsibility of the patient/guarantor and the patient/guarantor agrees to reimburse Family Medical Center for any fees of the collection agency and will be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including attorney's fees, we incur in such collection efforts. Collection fees will be added to the account at the time it is placed with a collection agency.
11. Completion of forms such as FMLA, Disability, and Disabled Placard are subject to a $25.00 charge if not completed during an office visit.
12. A patient may request a copy of their medical record. Requests must be submitted in writing and signed by the patient or parent/guardian if the patient is a minor child. Patients must allow 10 working days for medical records requests to be processed. In most cases, there is no charge to the patient if medical records are forwarded to another physician/clinic for continued care. If a patient requests a copy of the medical record for personal use, a charge of $25.00 will be assessed for 1-50 pages. An additional charge of $.50/page will be assessed for medical records of greater than 50 pages. The patient must pay the duplication fees prior to release of the copies. The clinic and staff recognize the importance of maintaining the confidentiality of each patient's private health information and are therefore trained in appropriate medical records and confidentiality laws and procedures.

We understand that unforeseen circumstances and temporary hardships may affect timely payment of your balance. We encourage you to 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 medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare and Medicaid.

Guarantor Signature

Patient Signature

Date

FAMILY MEDICAL CENTER

Agreement to Treatment

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 – The clinic receives the results of laboratory tests and diagnostic imaging within 48 business hours to one business week depending upon the particular test or procedure and the laboratory vendor. Upon receipt of the laboratory or imaging report, the ***provider*** must review and interpret the results and provide instruction or other feedback for the patient. **This process may take up to an additional week.** Patients receive the results of their laboratory tests or diagnostic imaging via the patient portal or by telephone, whichever the patient prefers. At the patient's request an alternate format may be used. ***Patients are asked to allow 10-14 days for results to be available, prior to inquiring at the clinic***. The providers or nursing staff will address any laboratory or imaging results requiring immediate patient follow up personally.

Medication Refills – ***Medication refills must be requested at the patient's pharmacy 5-7 days before they are needed***. 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 the patient has failed to follow up, is in need of laboratory or imaging studies, is requesting a refill too soon, or for various other reasons. ***Patients must allow our office 3-5 days to process medication refill requests.***

- Patients requiring triplicate prescriptions must call our office to request a refill at least 72 hours in advance.
- We do not refill antibiotics, narcotic pain medications or cough medications without an office visit.
- Medications will not be refilled outside of regular office hours.

After Hours – 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.

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.

Guarantor Signature

Patient Signature

Date

FAMILY MEDICAL CENTER

Informed Consent for Telemedicine Services

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:

- Patient medical records
- Medical images
- Live two-way audio and video
- Live audio only
- 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:

- Improved access to medical care by enabling a patient to remain in his/her home.
- 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:

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.

Parent/Patient Signature	Date

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PEDIATRIC HEALTH HISTORY

Completed By: _____ Relationship to Child: _____

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

_____

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

_____

Are 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 you take any medications or other drugs/substances during your 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.

PROBLEM		AGE	PROBLEM		AGE
☐	Asthma		☐	Heart Problems or heart murmur	
☐	Allergies		☐	Learning or school problems	
☐	Bedwetting/daytime accidents		☐	Menstrual problems	
☐	Behavior/Emotional problems		☐	Physical or sexual abuse	
☐	Broken bones		☐	Scoliosis or back trouble	
☐	Cerebral palsy		☐	Skin problems	
☐	Chicken pox		☐	Sleep problems	
☐	Chronic constipation		☐	Seizures	
☐	Depression or 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 ☐ 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 parents? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other

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

☐ Marriage ☐ Serious Illness ☐ Births ☐ Deaths
☐ Separation ☐ Divorce ☐ Loss of Job ☐ Other

Do any household members smoke? ☐ Yes ☐ No

FAMILY HEALTH INFORMATION – *Is there a family history of any of the following problems?*

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

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HEALTHY HABITS (2-18 year olds)

1. How many servings of fruit and vegetables does your child usually eat each day?
   ☐ Fruit ☐ Vegetables
2. How many servings of milk does your child drink each day? ☐
   What type of milk? ☐
3. How many servings of other beverages does your child drink per day?
   ☐ 100% Juice ☐ Soft drinks/sodas ☐ Water
   ☐ Other sweetened drinks (sports drinks, fruit drinks, sweet tea)
4. How often does your child eat fast food? ☐ per week
5. How often does your child eat breakfast? ☐ per week
6. How often does your family eat dinner together at the table? ☐ per week
7. How many hours per day does your child watch TV/movies or plays computer/video games? ☐
8. Does your child have a TV or a computer in his bedroom? ☐
9. How much time per day does your child spend in active play/exercise? ☐
10. Do you have any family history of high cholesterol or heart disease? ☐
11. What would you like to see your child change?

- ☐ Eat More fruits/vegetables
- ☐ Eat less fast food
- ☐ Drink less soda/other sweetened drinks
- ☐ Switch to low fat (skim) milk
- ☐ Drink more water
- ☐ Less time watching TV & playing video games
- ☐ Play outside more often
- ☐ Other? ☐