

# 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		City	State	Zip
Home Phone	Cell Phone	Work Phone		
Email		Social Security #		
Marital Status <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated				
If student, Name of School		City	State	
Patient's or Parent's Employer		Work Phone		
Employer Address		City	State	Zip
Whom may we thank for referring you?				
Emergency Contact		Phone		
Nearest Relative Not Living With You		Phone		
Nearest Friend Not Living With You		Phone		

Guarantor		Relationship to Patient		
Address		City	State	Zip
Home Phone	Cell Phone	Work Phone		
Date of Birth	Social Security #	Is this person currently a patient in our practice? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Insurance Company		ID#	Group #	
Address		City	State	Zip
Phone				

Insured Party		Relationship to Patient		
Address		City	State	Zip
Date of Birth	Social Security #			

Do you have any additional insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If, Yes, please complete the following:	
Insurance Company		ID#	Group #		
Address		City	State	Zip	
Phone					
Insured Party		Relationship to Patient			
Address		City	State	Zip	
Date of Birth	Social Security #				

I generally pay for my office visits using:    Cash    Check    Credit Card    Debit Card    HSA Card

*I certify that the information provided above is true and correct to the best of my knowledge. I will notify Family Medical Center of any changes in the above information.*

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date





**Financial Policy**

Thank you for choosing **Family Medical Center** as your primary healthcare provider. The following is our Financial Policy. If you have any question 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 medical care 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 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 15 minutes late for a scheduled appointment 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 with applicable collection fees (35% of account balance). All collection fees are the sole responsibility of the patient.
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 20 working days for medical records requests to be processed. 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.

\_\_\_\_\_  
Printed Name of Guarantor

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



**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. 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 by mail, email or 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 3 - 4 days before they are needed.* The pharmacy will fax 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 as required, is in need of laboratory or imaging studies, is requesting a refill too soon, or for various other reasons. *Patients must allow our office 24 - 48 hours 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 8:00 am - 12:00 pm and 1:30 pm - 5:00 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.

\_\_\_\_\_  
Printed Name of Guarantor

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



# FAMILY MEDICAL CENTER

## CHILD HEALTH RECORD/CHILD MEDICAL HISTORY

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX:  Male  Female

### **MEDICAL HISTORY**

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_  Patient is Adopted

Hospital \_\_\_\_\_

Maternal Complications  Maternal Substance Abuse  
If yes, please explain.

Was your child full term or pre-term (4 or more weeks early)? \_\_\_\_\_

Were there any problems during your pregnancy? Did you take any medications during your pregnancy? If yes, please explain. \_\_\_\_\_

Did your child have any problems right after birth? If yes, please explain. \_\_\_\_\_

Has your child every stayed overnight in the hospital? If yes, when and for what problem? \_\_\_\_\_

Has your child ever had an operation? If yes, what was it and when? \_\_\_\_\_

Has your child taken any long-term medications (more than 2 weeks)? If yes, what? How long was the medicine continued? \_\_\_\_\_

Does your child have any medication allergies? If yes, please list. \_\_\_\_\_

Are your child's immunizations up to date? Please provide us with your child's immunization record. \_\_\_\_\_

If your child has ever had any of the following problems, please check the problem and write how old they were when it started or when they had it.

PROBLEM	AGE	PROBLEM	AGE
<input type="checkbox"/> Asthma		<input type="checkbox"/> Frequent headaches	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Hearing problems	
<input type="checkbox"/> Bedwetting/daytime accidents		<input type="checkbox"/> Any heart problem or heart murmur	
<input type="checkbox"/> Behavior problems		<input type="checkbox"/> Learning problems	
<input type="checkbox"/> Bladder or kidney infection		<input type="checkbox"/> Menstrual problems	
<input type="checkbox"/> Broken bones		<input type="checkbox"/> Physical/sexual abuse	
<input type="checkbox"/> Cerebral palsy		<input type="checkbox"/> Problems with eyes or vision	
<input type="checkbox"/> Chicken pox		<input type="checkbox"/> Scoliosis/back trouble	
<input type="checkbox"/> Cigarette smoke exposure		<input type="checkbox"/> School problems	
<input type="checkbox"/> Concussion		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Constipation		<input type="checkbox"/> Skin problems	
<input type="checkbox"/> Depression		<input type="checkbox"/> Sleep problems	
<input type="checkbox"/> Developmental delay		<input type="checkbox"/> Sexual concerns	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Speech difficulties	
<input type="checkbox"/> Emotional problems		<input type="checkbox"/> Trouble sleeping	
<input type="checkbox"/> Frequent ear infections		<input type="checkbox"/> Other problems	

Do you have any concerns or questions about any of the above problems today?

# FAMILY MEDICAL CENTER

## **SOCIAL HISTORY**

Child's School: \_\_\_\_\_ Grade: \_\_\_\_\_ Average Grades: \_\_\_\_\_

Father: \_\_\_\_\_  Married  Divorced  Separated  Remarried

Father's Age: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_ Last Grade Completed: \_\_\_\_\_

Mother: \_\_\_\_\_  Married  Divorced  Separated  Remarried

Mother's Age: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_ Last Grade Completed: \_\_\_\_\_

Brothers and Sisters:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Other Guardian's or Caretaker's Name: \_\_\_\_\_

With whom does your child live? (If split custody, please describe the arrangement) \_\_\_\_\_

Who is the primary caregiver at home? \_\_\_\_\_

Has there been any recent family stress or social change? \_\_\_\_\_

## **ENVIRONMENTAL HISTORY (please check all that apply)**

- City Water  Well Water  Bottled Water  Tobacco Smoke in Home  
 Daycare  Household Pets  Recent Travel  Unusual Chemicals or Toxins

## **VALUES/BELIEFS ASSESSMENT**

Religious Reference: \_\_\_\_\_

Do you have any beliefs that might affect how we care for your child? (For example, some people refuse blood products or treatments because it is against their religious/cultural beliefs)

Please explain: \_\_\_\_\_



# FAMILY MEDICAL CENTER

## **FAMILY HEALTH INFORMATION**

Please review the conditions below. If anyone in your child's family (parents, grandparents, brother/sister, aunts, uncles or cousins) has any of these conditions, check the box. Please note how that person is related to your child.

Disease	Relationship	Disease	Relationship
<input type="checkbox"/> Alcohol Abuse		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Learning Problems	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Mental Illness, Suicide, Trouble with Nerves	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Seizures	
<input type="checkbox"/> High Cholesterol		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Deafness		<input type="checkbox"/> Sudden Unexplained Death	
<input type="checkbox"/> Domestic Violence		<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Adult Onset Diabetes		<input type="checkbox"/> Tobacco Abuse	
<input type="checkbox"/> Childhood Onset Diabetes		<input type="checkbox"/> Any Rare Inherited Disease	
<input type="checkbox"/> Drug Abuse		<input type="checkbox"/> Other Diseases	
<input type="checkbox"/> Heart Attack (less than 65 years old)		<input type="checkbox"/> Other Diseases	

## **FINANCIAL ASSESSMENT**

Do you currently use any of the following resources?

- AFDC     
  ECI/Child Team     
  Food Stamps     
  Home Nursing  
 CIDC     
  WIC     
  SSI     
  Other \_\_\_\_\_

Do you have any problems getting your child's medicine? \_\_\_\_\_

Do you have any difficulties getting to your doctor's appointments? \_\_\_\_\_

Do you have a regular social worker or case manager? \_\_\_\_\_

FORM COMPLETED BY: \_\_\_\_\_

RELATIONSHIP TO CHILD: \_\_\_\_\_

PARENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S INITIALS: \_\_\_\_\_ DATE: \_\_\_\_\_