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
City		State	Zip Code
Home Phone	Cell Phone	Work Phone	
Email		Social Security #	
Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated			
Patient's or Parent's Employer			Work Phone
Whom may we thank for referring you?			
Emergency Contact			Phone

Please Complete for Minor Children

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? ☐ Yes ☐ No		

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:

☐ By Telephone at:_____. This is my ☐home phone ☐cell phone ☐work phone.
- ☐ OK to leave message with detailed information. *We cannot leave detailed information on an answering machine if the answering machine message does not indicate your name.*
- ☐ Leave message with call back number only.

☐ Written Communication at: ☐My home address
☐My FAX _____ ☐My email _____

This release authorizes Family Medical Center to discuss non-sensitive medical information (such as lab test results, appointment verification, etc.) with: ☐Patient Only ☐Spouse ☐Parent ☐Other (please specify)_____

_____ _____
Patient/Guarantor Signature Date

_____ **(Please Initial)** I have received and/or reviewed a copy of *Privacy and Your Health Information* regarding HIPAA privacy practices.

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 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 (33% 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 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.

_____ _____

Printed Name of Guarantor Printed Name of Patient

_____ _____

Guarantor Signature Date Signature of Patient 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 or lab 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 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/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 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

PEDIATRIC HEALTH HISTORY

CHILD'S NAME:_____DOB:_____SEX: ☐ Male ☐ Female

Form 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	

FAMILY MEDICAL CENTER

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

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

PHYSICIAN'S INITIALS:_____ DATE:_____