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

MUST BE COMPLETED 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 work 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 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.

_____ _____

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 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.

_____ _____

Printed Name of Guarantor Printed Name of Patient

_____ _____

Guarantor Signature Date Signature of Patient Date

FAMILY MEDICAL CENTER

Health History

Name : _____ **Date of Birth :** _____

Have you ever been diagnosed with any of the following?		
❑ Stroke	❑ Tuberculosis	❑ Immune Disorder
❑ Neurological Disorder	❑ Diabetes	❑ HIV/AIDS
❑ High Blood Pressure	❑ Peptic Ulcers	❑ Bleeding Disorder
❑ High Cholesterol	❑ Colon Polyps	❑ Mental Health Issues
❑ COPD	❑ Osteoporosis	❑ Cancer
❑ Asthma	❑ Musculoskeletal Issue	❑ Insomnia
❑ Depression	❑ Anxiety	❑ Sleep Apnea
❑ Thyroid Disease	❑ Heart Disease	❑ Acid Reflux
❑ Enlarged Prostate	❑ Gout	❑ Seizures
❑ Other	❑ Other	❑ Other

Preventative History	
Date of Last Colonoscopy	
Date of Last Influenza Vaccine	
Date of Last Pneumonia Vaccine	
Date of Last Tetanus Booster (TDaP)	
Date of Last Bone Density Screening	
Date of Last Mammogram	
Date of Last Pap Smear	

Drug Allergies

_____

_____

_____

Current Medications

_____

_____

_____

Prior Surgeries/Hospitalizations

_____

_____

_____

Women Only

Age menstruation began _____ # of Pregnancies _____ # of Live Births _____

Pregnant? ☐Yes ☐No Planning Pregnancy? ☐Yes ☐No

Men Only

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ☐Yes ☐No

How often does this occur? ☐Frequently ☐Sometimes ☐Rarely

FAMILY MEDICAL CENTER

Social History	
How would you rate your general health?	☐Excellent ☐Good ☐Average ☐Fair ☐Poor
What is your marital status?	☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
How would you describe your occupation?	
What is your employment status?	☐Fulltime ☐Parttime ☐Unemployed ☐Retired ☐Disabled ☐Self ☐Student
What is your living situation?	☐Alone ☐With family members ☐With caregiver ☐Assisted living
Do you use alcohol?	☐Never ☐Rarely ☐Moderate ☐Daily
Do you use tobacco products?	☐No ☐Quit (When) ☐Yes (# packs/day # years)
Do you use drugs?	☐No ☐Yes Type/Frequency
Do you drink caffeinated beverages?	☐No ☐Yes Amount/day
Do you exercise outside of normal daily activities?	☐5+ days/wk ☐3-4 days/wk ☐1-2 days/wk ☐occasionally ☐zero Exercise consists of
What is your stress level?	☐Low ☐Medium ☐High

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						
Arthritis						