Family Medicine Center
at 34th & Coulter
James D. Hale, MD

Date: ______________________________

Name____**DOB**______________________________

Previous Primary Care Physician____

Specialists____

Medications____

____

Allergies____

Immunizations: Pneumovax? Yes/No Date__________________ Hepatitis B? Yes/No Date____________________
TD Booster? Yes/No Date__________________ Flu Shot? Yes/No Date ____________________
Hepatitis A? Yes/No Date__________________ Shingles? Yes/No Date____________________

Family History: Mother ________ Age__________ Medical Issues __________________________________
Father _________ Age__________ Medical Issues __________________________________
Brothers? Yes or No How many________ Medical Issues ________________________________
Sisters? Yes or No How many________ Medical Issues ________________________________

Patient Medical History: Have you had any of the following? (Please circle those that apply to you)

Diabetes	Stroke	Cancer (please specify) ______________________	
Hypertension	Heart attack	Blood Clots	Kidney Stones
PUD/GERD	COPD	Asthma	Thyroid Problems
Hepatitis	Other: _____________________		

Diagnostic Procedures:

Mammogram	Last Done: _______________	Where? ______________________________
PAP Smear	Last Done: _______________	Where? ______________________________
Bone Density	Last Done: _______________	Where? ______________________________
Colonoscopy	Last Done: _______________	Where? ______________________________
EGD	Last Done: _______________	Where? ______________________________
Stress Test	Yes or No	If yes, when and by whom? ______________________________
Heart Cath	Yes or No	If yes, when and by whom? ______________________________

Surgeries: Please list surgery and date.

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Social History:

Do you currently use Tobacco? **Yes/No** (If yes, circle that apply to you) **Smoke/Chew/Snuff/ Vape/Cigars/Other**_____

If yes, how much and for how long? ____

Do you drink Alcohol? **Yes/No** (If yes, circle that apply to you) **Beer/Liquor**

If yes, how much and for how long? ____

Do you drink Caffeine? **Yes/No** (If yes, circle that apply to you) **Tea/Coffee/Soda/Other**____________________

If yes, how much and for how long? ____

Do you currently use any illegal drugs? **Yes/No** If yes, how much and for how long? ____________________________

Do you ever use IV drugs? **Yes/No** If yes, how much and for how long? _______________________________

Do you have any tattoos/piercings? **Yes/No** If yes, how many of each? _______________________________

PATIENT INFO:

Last Name:		Previous: Primary Physician:		
First Name:		MI	Referring Provider:	
Address:		DOB:	Sex:	Marital Status:
City:		S.S.#		
State:	Zip code:	Employer Name:		
Home #	Cell #	Emergency Contact Name		
Work #		Emerg. Contact Relation	Emerg. Contact #	
Pharmacy Name & Location:				

Responsible PARTY INFO: (Person who is known as the primary member/carrier of Ins. If same as above, leave section blank)

Last Name:		DOB:	Sex:	Marital Status:
First Name:	MI	Relationship to patient:		
Address:		S.S.#		
City:		Employer Name:		
State:	Zip code:	City/State/Zip:	May we contact you at work:	
Email:	Home #	Cell #	Work #	

INSURANCE INFORMATION:

Insurance Name:	Policy Holder Name		
Policy / ID Number	Group Number		
Insurance Address	City	State	Zip
Policy Holder S.S.#	Date of Birth	Policy Holder Employer	
Policy Holder Address if different than above	City	State	Zip Code

Consent to Treatment: I voluntarily consent to receive medical and health care services provided by Family Medicine Center physicians, employees and such associates, assistants, and other healthcare providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment.

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SIGNATURE **DATE**

Patient Portal Authorization on the Web

Patients are set up with a secure User ID and password, enabling them to access our secure Patient Portal to view their health records, including lab and diagnostic test results, educational information, billing statements, and other health information. You can also send a message to the office through the Portal.

BY SIGNING BELOW, YOU ARE ACCEPTING RESPONSIBILITY TO CHECK YOUR LABS AND MESSAGES THE PORTAL INSTEAD OF HAVING THE NURSING STAFF CALL YOU WITH THE INFORMATION/RESULTS.

IN ORDER TO PROVIDE YOU ACCESS TO THE PATIENT PORTAL, PLEASE PROVIDE US YOUR EMAIL ADDRESS

EMAIL ADDRESS:____

☐@YAHOO.COM ☐@GMAIL.COM ☐@HOTMAIL.COM ☐@SUDDENLINK.NET ☐@SBCGLOBAL.NET

IF YOU WISH TO DECLINE THE PORTAL REQUEST, SELECT ONE OF THE BOXES BELOW:

☐ I do not have an email address. ☐ I do not want to access the Patient Portal.
☐ I do not want to share my email address. ☐ I already have access to the Patient Portal.
☐ Other ____

____

SIGNATURE **DATE**

Patient's Consent to Obtain External Prescription History

I grant permission to the healthcare providers at FMC to view my prescription history from other external sources (other pharmacies and/or providers.) I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, pharmacy benefit managers may be viewable by my providers and staff, and it may include prescriptions back several years.

____

SIGNATURE **DATE**

HIPAA

ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

Patient's Name: ____ Date of Birth: ________________________

Your medical information will not be released to anyone other than yourself or your designated representative. If you wish for a family member or other representative to have access to your information, please list their names below:

Name____ Relation ________________________________
Name____ Relation ________________________________
Name____ Relation ________________________________
Name____ Relation ________________________________

By signing below, you acknowledge that you have received the ***Notice of Privacy Practices*** effective September 23, 2013 prior to any service being provided to you by the practice, and that you consent to the use and disclosure of your medical information, except for any requested restrictions you must therefore explain below. ANYTHING YOU DO NOT WANT SPECIFICALLY AVAILABLE (Example: Diagnosis, lab results, Test Results, etc.) to those who are your designated representative of said records. (Example: Anyone mentioned directly above, wife, parents, etc.).

I hereby request the following restrictions for the use and/or disclosure of my information: Restrictions, if any, to be withheld:____

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____
SIGNATURE **DATE**

____
GUARDIAN/LEGAL REP. SIGNATURE DATE

Financial Policies and Responsibilities

BILLING OF ACCOUNT BALANCES: You are responsible for the allowed fee AT THE TIME OF YOUR VISIT. Afterwards, the claims are sent to your insurance company. If you receive a billing statement, then the payment is due upon receipt of that statement.

PAYMENT PLANS: We understand that from time to time unexpected circumstances may show up which makes paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. You may contact the Receptionists at our office at 806-350-8850 to set up a payment plan or contact the Billing office at 806-358-9400.

LIABILITY OR AUTO ACCIDENT CLAIMS: WE DO NOT BECOME INVOLVED IN AUTOMOBILE OR LIABILITY LAWSUITS, nor do we file liability claims or wait on "settlements". You will be required to pay in full for services rendered. We will provide you with the information necessary to be reimbursed (Receipts and/or records of your visits). You may contact the business office for a copy of HCFA at 806-358-9400.

WORKERS COMPENSATION CLAIMS: WE DO NOT PARTICIPATE IN WORKER'S COMPENSATION and are unable to file claims on your behalf. If you are injured on-the-job, you will be responsible for payments at time of service.

NSF CHECKS: We utilize the services of ReChek for any NSF items received (Returned Checks). Once returned, these items are handled directly by ReChek LP at 806-468-9233.

NON-PAYMENT OF ACCOUNTS: Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a national credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records will be provided if requested.

*** Please sign both signature requests below ***

ACCEPTANCE OF FINANCIAL POLICY: The undersigned hereby certifies that he/she has read, understood and agrees to the financial policies listed above of FMC

SIGNATURE DATE

ASSIGNMENT OF BENEFITS: The undersigned hereby requests that payment from authorized insurance carrier or state benefits program be made directly to the FMC provider who rendered services on their Behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier. *(Gives permission for the provider to file claims for office visits/rendered services and to release insurance information/records. In order to verify benefits, claims, and reimbursement for both patient and provider)*

SIGNATURE DATE

RELEASE OF MEDICAL RECORDS

Authorization to Disclose Health Information

Patient's Name:	Date of Birth:
Address:	SS#:
	Phone#:

Information to be released FROM:	Information to be released TO:
Facility:	Facility:
Phone:	Phone:
Fax:	Fax:

✓	I DO		I DO NOT	… authorize this information to be disclosed electronically.

I am requesting this information to be released for the following purpose:

Continued Care		Insurance		Legal/Personal		Other____________________________________

Requested data and Dates of services: Last 3yrs or other: ____

	Progress Notes		Labs		ER/Hospital		Shot Records		Consultations
	Xray/Imaging		EKG		Bone Density		Mammography		Other

SIGNATURE **DATE**

IF SIGNED BY LEGAL REP, AUTHORITY TO SIGN SIGNATURE OF WITNESS

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse. This type of sensitive information will only be released if specifically requested by checking "other" above and stating exactly what information is to be released. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 180 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact James D. Hale, M.D.'s Administrative Supervisor by calling 806-350-3010.