7629 Tiki Dr. @FM 1093
Fulshear, Texas 77441

P: (281) 346-0018
F: (281) 346-0913
FulshearFamilyMed.com

Adult Patient History

Patient Full Name: _____ Today's Date: _____
Primary Doctor: _____ Date of Birth:_____ Age:_____
Reason for visit:_____

List all chronic medical problems:

_____
_____
_____

List all medication dosages and frequency taken (including vitamins, minerals, and supplements):

_____
_____
_____

List all allergies / drug sensitivities and type of reaction:

_____
_____
_____

List all prior surgeries and date of surgery:

_____
_____

Family History:

Has any blood relative had any of the following: (Check Yes or No and describe the relationship)

	Yes	No	Relationship(s)		Yes	No	Relationship(s)
Allergies	☐	☐	_____	Depression	☐	☐	_____
Diabetes	☐	☐	_____	Psychosis	☐	☐	_____
Hypertension	☐	☐	_____	Substance Abuse	☐	☐	_____
High Cholesterol	☐	☐	_____	Migraines	☐	☐	_____
Heart Disease	☐	☐	_____	Seizure Disorder	☐	☐	_____
Stroke/TIA	☐	☐	_____	Glaucoma	☐	☐	_____
Asthma	☐	☐	_____	Cancer	☐	☐	_____
Tuberculosis	☐	☐	_____	Leukemia	☐	☐	_____
Thyroid Disease	☐	☐	_____	Anemia	☐	☐	_____
Kidney Disease	☐	☐	_____	Bleeding Tendency	☐	☐	_____

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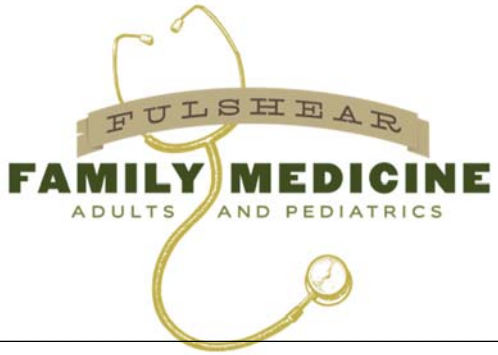

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Patient Full Name: _____

	Age	Health Status (Good, Fair, Poor)	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Spouse			

Social History:

Marital Status? Single _____ Married _____ Divorced _____ Widowed _____
Who lives with you? _____
Current Employer? _____
Current Occupation? _____
Highest Level of Education? _____
How would you rate your level of stress? Low _____ Medium _____ High _____
How do you rate your nutritional history? Good _____ Fair _____ Poor _____

	Yes	No		
Would you consider your eating habits nutritional?	☐	☐		
Are you a former smoker?	☐	☐	If yes, how long?	_____
Are you a current smoker?	☐	☐	If yes, how much?	_____
Do you drink alcohol?	☐	☐	If yes, how much?	_____
Do you use illicit drugs?	☐	☐	If yes, how much?	_____
Do you exercise regularly?	☐	☐	How often?	_____

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New Patient Information Form

Patient Name :_____ SS #: __ __ __ - __ __ - __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __ Age:_____ Sex: _____

Street Address: _____ City/ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Race:_____ Ethnicity:_____ Language: _____

Patient's Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

Insurance Company Name: _____ Type: _____

ID #: _____ Group #:_____

Policyholder's Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __

Policy holder SS #: __ __ __ - __ __ - __ __ __ __ Relationship to patient: _____

Policy holder's address (if different from above):

Street Address: _____ City / State: _____ Zip Code: _____

Home Phone: _____ Work / Cell Phone: _____

Assignment of Benefits / Release of Medical Information

I authorize the release of any medical information necessary to process medical claims filed in my behalf. I also request payment of government benefits and/or insurance medical benefits to the undersigned physician for the services described.

_____ _____
Patient Signature Date

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Permission to Release Information

Date:_____

I _____ give my permission to discuss my medical condition, results and history with _____ (relation to patient) _____. This letter is valid for all medical and billing information in my chart/file kept at Fulshear Family Medicine.

_____ _____
Signature Date

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Preferred Pharmacy Information

Patient Name: _____

Preferred Retail Pharmacy

Name of Pharmacy: _____

Street Address: _____

City: _____ State: _____

Phone Number: _____ Fax Number: _____

Preferred Mail Order Pharmacy

Name of Pharmacy: _____

Street Address: _____

City: _____ State: _____

Phone Number: _____ Fax Number: _____

In what quantity do you prefer to receive your prescriptions?

☐ 30 day supply

☐ 90 day supply

☐ Other: _____

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Patient Check Off List

(Please initial next to the documents listed once you have read and reviewed them.)

_____ **Patient Bill of rights**

_____ **Consent to Use and Disclosure of Health Information**

_____ **Patient Financial Responsibility**

_____ **Patient Notice of Privacy Practices**

_____ **Prescription Medication Policy**

I have read and reviewed all documents listed above via the website www.fulshearfamilymed.com or via hard copy provided by the office. I understand that by signing below it is my responsibility to follow all policies and requests in the documents listed above. If I have any questions or concerns regarding these policies/documents I am aware that I may contact the office at 281-346-0018.

_____ _____
Signature Date

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Patient Bill of Rights

- All patients will be fully informed of their rights.
- The patient has the right to appropriate, considerate, and respectful care.
- The patient has the right to receive information necessary to give informed consent prior to the start of any procedure.
- The patient has the right to treatment with respect, privacy, and dignity.
- The patient has the right to reasonable continuity of care.
- The patient has the right to be given reasonable notice of anticipated termination of services or of plans to transfer to another provider.
- The patient has the right to discuss problems with the physician without fear of discrimination.
- The patient has the right to be fully informed of the practice's policies and procedures.
- The patient and the public have the right to honest, accurate, forthright information regarding the health services provided.

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Consent to Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

I understand that as part of my healthcare, Fulshear Family Medicine originates and maintains health records describing my health history, symptoms, examination findings, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who contribute to my care.
- a source of information for applying my diagnoses and surgical information to my bill.
- a means by which a third-party payer can verify that the services billed were actually provided.
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and prior to implementation, will mail a copy of any revisions to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Fulshear Family Medicine is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

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Patient Financial Responsibility Statement

Payment of your bill is considered part of your treatment. If you have medical insurance, we stand ready to assist you in receiving your maximum allowable benefits. In order to do this, we need your help by understanding this statement of our financial policy.

Note: Full payment is due at the time of service.

Insurance Coverage: Please understand that as a health care provider and healthcare facility, our relationship is primarily with you and not your insurance company. As a courtesy and convenience to you, we will file insurance claims for all of our patients. We cannot bill your insurance company unless you give us *current and accurate* insurance information.

Co-payments and deductibles for all insurance plans must be paid at the time of service. Failure to pay co-payments will be reported to your insurance plan and to your employer. Co-payments are a condition of your insurance coverage, and you may be subject to termination of your insurance benefits if you do not pay them.

Method of Payment: Cash, check, Mastercard, Visa, Discover and American Express payments are accepted.

Patients without Insurance: Occasionally, our patients may find themselves without health insurance coverage. Our policy states that 100% of all anticipated charges must be paid **at the time of service**.

Non-Sufficient Fund Checks written to Fulshear Family Medicine will have a $25.00 fee assessed to your account.

A letter will be sent to you requesting payment for services rendered. If no explanation or payment is received within 14 days, the account will be turned over to an outside collection agency. Subsequent services will require cash payment in advance until the account is paid in full.

Patient Appointment Responsibility: When you do not keep your agreed upon appointment, three people are affected. Firstly, you do not receive the needed treatment prescribed by your physician. Secondly, another patient could have benefitted by utilizing your appointment time. Finally, the physician now has a gap in the schedule due to time reserved for you. Our policy requires that an appointment be cancelled 24 hours in advance. If this is not done, there could be a $25.00 charge that you will be responsible for. This charge will not be covered by your insurance plan.

Pre-Certification: Pre-Certification (prior approval) may be required by your insurance plan before certain procedures or diagnostic testing. Please allow 48-72 hours for this process to be complete. Please make sure that pre-certification has been given before proceeding with any procedure or diagnostic testing.

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FULSHEAR FAMILY MEDICINE
ADULTS AND PEDIATRICS

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Prescription Medication Policy

Fulshear Family Medicine handles a large amount of prescription refill requests in the form of calls from patients, faxes from patients and pharmacies, and electronic requests from pharmacies. In order to continue providing the highest quality medical care and ensure your safety, we have implemented the following prescription policy.

- Prior to your scheduled office visit, please look over all of your medications, inhalers, diabetes supplies, etc. to determine if you need to request refills during your visit with the physician.
- We ask that all patients bring his or her medications and supplements to the office visit for our nurses and physicians to review. This helps us keep an accurate record of all medications prescribed by all medical providers involved in your care.
- All chronic medications will require regular follow-up visits at our office. Your physician will determine the appropriate interval between visits. Please ensure that you have enough medication to last until your next scheduled visit. If you are overdue for your visit, your provider may provide enough medication to last until your scheduled appointment (maximum of 2 weeks supply).
- Medications for acute problems (cough, fever, etc) will require an office visit to ensure that a correct diagnosis is made and that an appropriate medication is prescribed.
- There are several methods on how to request a refill on your prescribed medication. The preferred method is to ask your physician during your scheduled office visit. If you need a refill between office visits and it is non-urgent, please call your pharmacy to have them send us a refill request. If the refill request is urgent, call our office directly to speak with our office staff. Please allow to the end of the business day for your refill request to be addressed by the physician.
- We offer the following options for prescription refills:
  - We can send most prescriptions electronically or via fax to local pharmacies.
  - We can call local pharmacies directly with your prescription information.
  - We can provide written prescriptions for you to pick up at our office.
- We are able to refill medications through mail order services. We prefer that you pick up a written prescription at our office so that you can check that the proper medication, dosage, and quantity were prescribed. Although rare, errors do happen, and you must be aware that mail-order pharmacies will not accept returns of incorrect medications and will not issue refunds. If you prefer, we can send medications either electronically or via fax to the mail order service; however, we will not be responsible for any refunds due to errors.
- Certain controlled medications such as some pain medications, anxiety medications, and medications for ADHD must be written on a triplicate prescription without refills. You are required to pick these medications up at our office.
- If you are changing pharmacies, please call the NEW pharmacy and request that your prescriptions be transferred from your OLD pharmacy. If they will not transfer, call our office to request that new prescriptions be sent to your new pharmacy.
- If you are going out of town for an extended period of time and will need refills during your trip, please have the pharmacy at your destination contact your local pharmacy to transfer your prescriptions. When you return, have your local pharmacy contact your destination pharmacy to reverse the process.
- Medications are prescribed for your use only and are not meant to be shared with others.
- Refills are not provided after business hours or on holidays.