

GEORGETOWN FAMILY MEDICINE

Kristy D. Heatly, D.O. Florence C. Spittler, D.O.
1900 Scenic Drive #1128 • Georgetown, Texas • 78626
512-864-2911 Fax: 512-864-2922

Patient Registration Form

Date: _____

Patient Information

| | | | |
|--|---------|---|----------------|
| Patient Name: | | | |
| Last | | First | M.Initial |
| Address: | | | |
| Street | | City | State Zip |
| Home #: | Work #: | Cell# | |
| Email address: | | | |
| Social Security Number: | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth: |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other | | | |
| Employer: | | Student: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Pharmacy: | | Phone #: | Location: |

Emergency Contact (Required)

| | |
|----------|--------------------------|
| Name: | Relationship to Patient: |
| Phone #: | |

Financially Responsible Party Information

| | | | |
|---|----------------|--------|----------------|
| Name: | | | |
| Last | | First | M. Initial |
| Address: | | | |
| Street | | City | State Zip |
| Social Security Number: | Date of Birth: | Phone: | |
| Relationship to Patient: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other: | | | |

Insured Party (Subscriber)

| | | | |
|-------------------------|----------------------|--------|----------------|
| Subscriber Name: | | | |
| Last | | First | M.Initial |
| Address: | | | |
| Street | | City | State Zip |
| Insurance Company: | Date of Birth: | Phone: | |
| Member/ID #: | Policy/Group # | | |
| Social Security Number: | Employer of Insured: | | |

PLEASE PRESENT INSURANCE CARD and DRIVERS LICENSE

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Patient Consent Form

Authorization to Treat

I give authorization to Georgetown Family Medicine to provide medical care to me and/or my family that is reasonable according to the present medical standards.

Use and Disclosure of Protected Health Information

I consent to allow Georgetown Family Medicine to use and disclose my Protected Health Information in order to carry out medical treatment, payment and healthcare operations.

Authorization/Insurance Payment

I authorize Georgetown Family Medicine to provide medical information to my insurance carrier and I authorize payment of insurance benefits to the Georgetown Family Medicine for services provided to me. If one determines that I do not have a right to this coverage, I accept financial responsibility for all charges for medical care provided to me and/or my family members by the physicians of Georgetown Family Medicine. The signature below represents the signature on the HCFA 1500 from Box 12 A that states "signature on file".

Authorization for Provision of Information

I authorize Georgetown Family Medicine to provide to my medical insurance company, Medicare or another of my third party organization all the medical information that is requested. I also authorize provision of all the medical information needed to a consulting physician who is involved in my care.

Authorization to Leave Voice Messages and/or Email

I authorize Georgetown Family Medicine to leave messages by voice or email at my home or employment reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that no message will be left regarding confidential medical information unless specifically authorized by my doctor and myself.

Authorization to Release Medical Information

I authorize Georgetown Family Medicine to release medical records or medical information to:

____ Spouse: Name _____

____ Other: Name _____

By signing this form, I am consenting to Georgetown Family Medicine use and disclosure of my protected medical information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. Understand that I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

Acceptance of these provisions continued effective until I send a letter of revocation to Georgetown Family Medicine.

Signature of Patient or Legal Guardian

Date _____

Print Patient's Name

Print Name of Parent/ Legal Guardian

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Financial Policy

We appreciate payment at the time of service and will accept personal checks, VISA, MasterCard and Discover. Prompt payment helps keep both our costs and fees down. After your medical care is completed, you will be directed to our checkout desk. There you can receive receipt of your payment of insurance co-pay or fee for services.

Our insurance staff will electronically file most insurance claims and periodically advise you of the progress of the claim.

Our Physicians share your concern about the cost of medical care. We strongly believe that the best medical service is based on a friendly, mutual understanding between doctor and patient. We therefore invite you to discuss frankly with us any questions you may have regarding our services or fees. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our office administrator, Jennifer Ready. The earlier we know about a possible problem, the better we are able to develop suitable options for you.

AGREEMENT

This is an agreement between Georgetown Family Medicine, as provider, and the Patient named on this form. By executing this agreement, you, Patient, are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. Payments not received within 15 business days of receipt of statement are considered past due

Payment options if you have no insurance:

- A. Payment is required at the time of service. We do offer a prompt pay discount for those in this situation.

Payment options if you have insurance:

- A. You must pay all deductibles, co-pays, and co-insurances in full time of service. You may choose to pay with cash, check, or credit card.
- B. Patients must pay co-pays or deductibles before surgical procedures are performed and at the time that office services are rendered, if there is no insurance carrier contract provision to the contrary.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance if you have provided correct information. Although we may estimate what you insurance may pay, the insurance company makes the final determination of you eligibility. You agree to pay any portion of the charges not covered by insurance.

Required Co-Payments: Any **co-payment** required by an insurance company **must** be paid at the time of service by contract. We cannot bill you for these fees. If you fail to bring your co-pay with you to your visit your appointment may need to be rescheduled.

Returned checks: There is a fee of \$25.00 for checks returned by the bank. If a returned check is received on your account you will be required to pay all fees associated with this check (and all future visits in cash prior to being seen). Advance cash payment for future visits may be required.

Fees for appointments missed without 24 hours advance notice may be charged the following:

- 1) Routine appointments \$25.00
- 2) Extended (physical exam procedure) appointments \$80.00.

Fees must be paid prior to scheduling a new appointment.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we are forced to refer your collection balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Williamson County, Texas.

Divorce: Consistent with Texas statute, in case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. **If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.**

Account Summary fee: For printed Account Summaries for the most recent calendar year (flex plans, income tax, court purposes, etc.) there is a \$5.00 fee for each account summary printed after one complimentary copy per year.

Workers Compensation: We do not provide treatment for work-related illness/injury. If you do not disclose your visit is job related, you are financially responsible for all charges incurred for that visit.

Person Injury/MVA: We do not bill attorneys for medical services. Any services performed in relation to a personal injury case must be paid in full at time of service.

Disputes: You should notify us of discrepancies in writing immediately. We will investigate and resolve your dispute within 30 days.

Additional Services: Please be aware that there are fees for additional services such as prescriptions rewrites, copying medical records, depositions, and special forms. Please check with the office staff for specific fees for additional services.

Date: _____

Patient's name: _____

Responsible Party
(if not the patient): _____

Signature: _____

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Initial Clinical History and Physical Form

Date: _____

Patient Information

Name: _____ Age: _____ Date of Birth: ____/____/____

Race: Caucasian ___ African-American ___ Asian ___ Hispanic ___ Multi-Racial ___ Other _____

Sex: M ___ F ___ Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ # Children ___

Previous Family Physician _____ Referring Physician _____

Reason for visit _____

Past Medical History

(Please check all conditions that you have or have had)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Allergy: Food |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Difficulties | <input type="checkbox"/> Seizure | <input type="checkbox"/> Allergy: Seasonal |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis A B or C | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> TB |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> HIV | <input type="checkbox"/> Arthritis(Type)_____ | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Diabetes diet controlled | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Coronary Artery disease | <input type="checkbox"/> Diabetes- oral meds | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes on insulin | <input type="checkbox"/> Osteoporosis | |

Cancer: Type/Treatment _____

Other (specify) _____

Past Surgical History

Type of Surgery and Year

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Prescription Medications

- | Medication | Dose/Number per Day | Medication | Dose/Number per Day |
|------------|---------------------|------------|---------------------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

Non-Prescription Medications

- | Medication | Dose/Number per Day | Medication | Dose/Number per Day |
|------------|---------------------|------------|---------------------|
| 1. _____ | _____ | 4. _____ | _____ |
| 2. _____ | _____ | 5. _____ | _____ |
| 3. _____ | _____ | 6. _____ | _____ |

Patient Name: _____

Allergies/Type of Reaction

No known drug allergies
 Latex
 Tape
1. _____ 3.. _____
2. _____ 4.. _____

Social History

(Please check the appropriate listings)

Tobacco Use **Alcohol Use** **Drug Use** **Exercise**
 Never None None None
 Quit When: _____ Socially Marijuana 1-2x/week
 Cigarettes Packs/day: _____ Daily Amphetamines 3-4x/week
 Pipe Heavy Other _____ 5-7x/week
 Cigars
 Chewing tobacco
 How many years
Have you ever been Have you ever been
Treated for alcoholism? Treated for drug use?

Caffeine Use

None Yes No Yes No
 Occasional If yes, when? _____ If yes, when? _____
 Daily
How much? _____

Any religious beliefs that would affect your medical care? _____

Education

Please check highest level
 Grade School High School College Post Graduate

Occupational History

Employer: _____ Job Title: _____

Have you altered your job as a result of the problem that brought you here today? Yes No

If Yes, please explain: _____

If you are currently off work as a result of the problem, How long have you been off work? _____

Family History

| | | | | |
|---------|--|------------|---|--|
| Father: | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | Age: _____ | Medical History: or Cause of Death: | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ Other: _____ |
|---------|--|------------|---|--|

| | | | | |
|---------|--|------------|---|--|
| Mother: | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | Age: _____ | Medical History: or Cause of Death: | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ Other: _____ |
|---------|--|------------|---|--|

| | | | | |
|-----------|------------------------------------|-------------------------|---|--|
| Brothers: | # Living _____ # Deceased _____ | Age: _____ Age _____ | Medical History: or Cause of Death: | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ Other: _____ |
|-----------|------------------------------------|-------------------------|---|--|

| | | | | |
|----------|------------------------------------|--------------------------|---|--|
| Sisters: | # Living _____ # Deceased _____ | Age: _____ Age: _____ | Medical History: or Cause of Death: | <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ Other: _____ |
|----------|------------------------------------|--------------------------|---|--|

Patient Name: _____

Review of Systems

Please check any of the following you currently experience:

- General**
 Weight loss
 Weight gain
 Fever
 Fatigue
 Night sweats
 Insomnia

- Eyes**
 Pain
 Discharge
 Light sensitivity
 Blurred Vision
 Double Vision

- ENT**
 Sinus pain
 Sneezing
 Sore throat
 Hoarseness
 Ear ringing/ear pain
 Nose bleeds
 Itchy throat/eyes
 Nose bleeds
 Nasal congestion
 Post nasal drip
 Runny nose

- Cardiovascular**
 Chest pain
 Fainting
 Feet swelling
 Palpitations/
Irregular heartbeat
 Shortness of breath
exertion
 Shortness of breath
lying down

- Gastrointestinal**
 Abdominal pain
 Nausea
 Vomiting
 Diarrhea
 Constipation
 Blood in stool
 Indigestion/Reflux
 Change/Bowel Habit

- Skin/Breast**
 Rash
 Itching
 Sores
 Abscess
 Discharge

- Genitourinary**
 Frequency
 Flank pain
 Painful urination
 Blood in urine
 Trouble starting
urine stream

- Neurological**
 Headache
 Confusion
 Numbness
 Slurred speech
 Seizure
 Tingling
 Dizziness/weakness

- Respiratory**
 Wheezing
 Cough-Recent
 Cough-Long lasting
 Shortness of breath
 Chest congestion

- Musculoskeletal**
 Joint swelling
 Joint redness
 Joint pain
 Gait problems
 Muscle pains/swelling

- Endocrine**
 Excess sweat
 Excess thirst
 Excess hot
 Excess cold
 Hair loss
 Increased nighttime
urination

- Hematologic / Lymphatic**
 Bleeding tendencies
 Lymph node swelling
 Easy bruising

- Psychological**
 Anxiety
 Depression
 Severe Stress
 Panic
 Eating disorder
 Bipolar

 Hallucinations

- GYN**
 Irregular menstruation
 Pelvic pain
 Hot Flashes
 Nipple discharge
 Post menopausal bleeding

For Females:

Are you pregnant? _____ Are you breast feeding? _____

Date of first menstrual period: _____ Date of last menstrual period: _____

of Pregnancies/Deliveries: _____ Last Mammogram: _____

Last Pap: _____ Bone Density Scan: _____

Type of Birth Control: _____

For Males:

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu: Date: _____ Pneumonia: Date: _____ Tetanus: _____

Other:

Screenings: _____ Colonoscopy Date: _____